	300.0	•	,	Department of Certificate of			leg. No.	6.	JUU!
Dhualala	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	ith Day	Yeer	3. Time of Death
Physician /Medical	Henrietta	A. Lefkow	itz			July	10,199		9:00 PM
Examiner	4a Facility Name (If not institution,	give street and number,)		4b. City, Town, or L	ocation of Death	4c. County	of Death	
	SHADY GROVE A		HOSPI		ROCKV If Under 24 Hrs.	ILLE		ITGOM	IERY
Funeral	5. Social Security Number 140 - 18 - 8749	6. Sex 7. Ag 1 ☐ M 2 ☐ XF	ge (In yrs. last bi	Yrs. Months Deys		(Month, Da)	, Year)	Counti	nce (State or Foreign nsylvania
Director	Usual Residence of Decedent		80			June	1,1919	rem	iisy i vaii i a
within 72 hours after death with the Maryland she. than "natural", or frems 23s or 28s-1 show he Medical Examiner must be notified at ompleted by Funeral Director	10e. State 10b. County		10c. City, Tov	n or Location				10	d. inside City Limits
Man Half	MD. Mont	gomery	Silv	er Spring					XIXYes 2□ No
or 28.	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
23a	3115 Helsel	Dr.		2090	06		Unite	d Sta	ates
r tems 23e or 28e-1 el iner must be notified Funeral Director	11. Maritai Stetus	12. Was Decedent Armed Forces	Ever in U,S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Raci Bled	e - America k, White, e	
it, or h	1 Never Married 2 Marrie	If Yes, Give		1 ☐ Yes 2 🔀 No	Specify:		Specify	7471-	* 4 -
pd b	3 Nidowed 4 □ Divorced	Year or Dates:		. Decedent's Usual Occu	ination		16b. Kind of Bu		ite
yglene. ner than "natura it, the Medical E Completed	15. Decedent's (Specify only highest	grade completed)		(Give kind of work done life. DO NOT use retin	o during most of worked)	king	TOO. KING OF BU	1511123211100	Johny
Hyglene. ther than ent, me	Elementary/Secondary (0-12)	College (1-4or	5+)	Homemal			Own	Home	
in Mental trygens. merical other than "natural" or items 23a or 28a-f show matic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	17. Father's Name (First, Middle, L.				18. Mother's Nam	ne (First, Middle,			
arked atic ev	Leo M. Abr	ahams			Fay B	urger			
If item 27 is marks or other traumatic To	19a. informant's Name/Relationshi	p (Typa, Pnint)	19	b. Malling Addrass (Street	et and Number or Ru	ral Route Numbe	er, City or Town,	State, Zip	Code)
em 27 i	Edward L. L	efkowitz-		115 Helse	l Dr. Si	1ver S			
i ite	20a. Melhod of Disposition 12 Burial 2 □ Cremation	3 Demoval from State	comete	of Disposition (Name of ery, crematory or other pi	ace)	Date	20c. Location -	City or Tov	vn, Stete
	4 Donetion 5 Other (Spe			Israel Me			Woodb		
important: any injury once.	21. Signature of Funeral Service Li	censee		22. Name and Adds	ess of Facility T	akoma	Funera	1 Hor	me.
0 5 3 8	Kegenaly 1	1/E		254 Car:	roll St.	NW. W	ashing	ton !	DE.20012
1000	23a. Part1. Der the diseese, or c shock, or heart failure. List o	omplications that cause nly one ceuse on eech	ed the death. Do	not enter the mode of dy	ring, such es cardiac	or respiratory ar	rast,		Approximate Interval Between
ysician			1		,				Onset and Death
Medical aminer	immediate Cause (Final disease or condition rasulting in death)	e. (0)	ad suge	use Sh	ver			-	34
	Tabling III obally	m	Due to (of as a		/ - A	- 0/			- /
n and ial-transit Examiner		b. 140	U/20/	yccordsul	- funde	ve ho	~	C	04.
chysician and the burial-transit dical Examir	Sequentially list conditions, if any, leading to immediata ceusa. Entar Underlying Ceuse (Disease or Injury	1	Due to for as a	consequence of): yor explain yonsequence of): y A 4	1.	/		1	la s
the bur	triat militated events	c	V 0 4 0-	onsequenca of):	uerosc	180050	3		TOL
as the	resulting in death) Last		2	y					
attending pl of or use as t clan/Med		d							
etached for use as Physician/Me	Pert II. Other significant condition	s contributing to death	but not resulting	in the underlying ceuse g	iven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
ed by the detached						10	Yss 2X No	3 Prob	ably 4 Unknown
by by									
should should leted							an autopsy med?	ava	re autopsy findings illable prior to
200									npletion of cause leath?
Page Con						101	res 2 No	10	Yes 2□ No
Be Be	25. Was case referred to medical examiner?	12				ath (Check only o	one)		
aldire of :	1 ☐ Yes 2 No	Hospital:		utpatient 3LI DOA		lome 5 Resid)
After funen	27. Mannar of Death 1 So Natural 5 □ Panding		ay Year) 28b.	Time of Injury 28c. Inj	uryat ork? ⊒Yas 2 ⊒No	∠ga. Describe l	now Injury occur	re0	
tor:	2 Accident Investige 3 Suicide 6 Could no	ot be One Diseasef is	niuny - At home 4			28f. Location /	Street and Numb	per or Rumi	Route Number
al Director: After tied in by the funers Certification:	4 Homicida determin	and 286. Place of in	njury - At home, i etc. <i>(Specify)</i>	arm, street, factory, office	7	City or To	vn, State)	A OF FIGURE	
completely filled in by the funeral Medical Certification: 1	29e, Certifier 170 Certifying	Physician: To the hest	of my knowledge	e, death occurred at the	time, date and place	, and due to the	cause(s) and me	anner as st	ated.
pletely fill edical			of exa <i>mi</i> nation a	nd/or investigation, in my					
To the Funeral Director: After completely filled in by the funeral Medical Certification	29b. Signature and title of certifier	1	1		nse number		29d. Dete signe		
D	1///	1 1/11/	1	0	44340)	JU14	10.1	999
	30. Nama and address of person w	no complated cause of	death (Item 23a)	(Type, Print) Center D	A		1		
	Angelo Falco	Occ.	Medica	1 Center D	rue Roc	Lville.	man	land	20850
State	31. Date Mad (Month, Day, Year)		rer's Signeture				1		

State Registrar

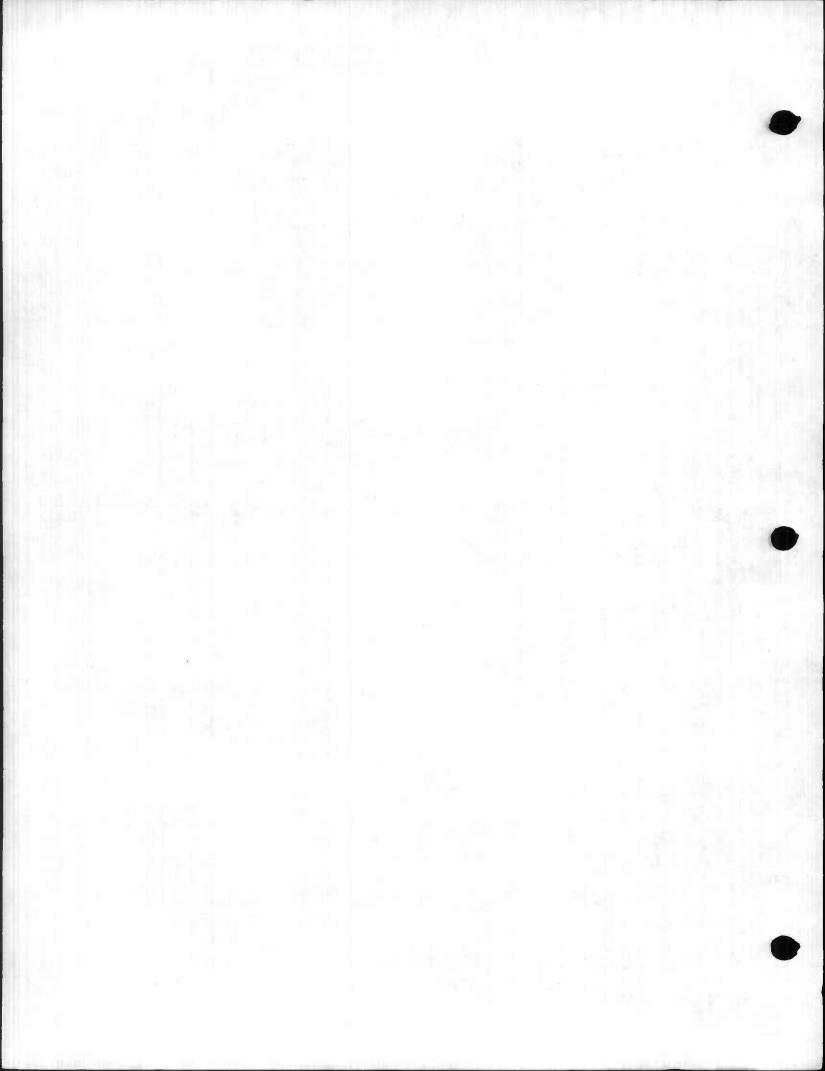
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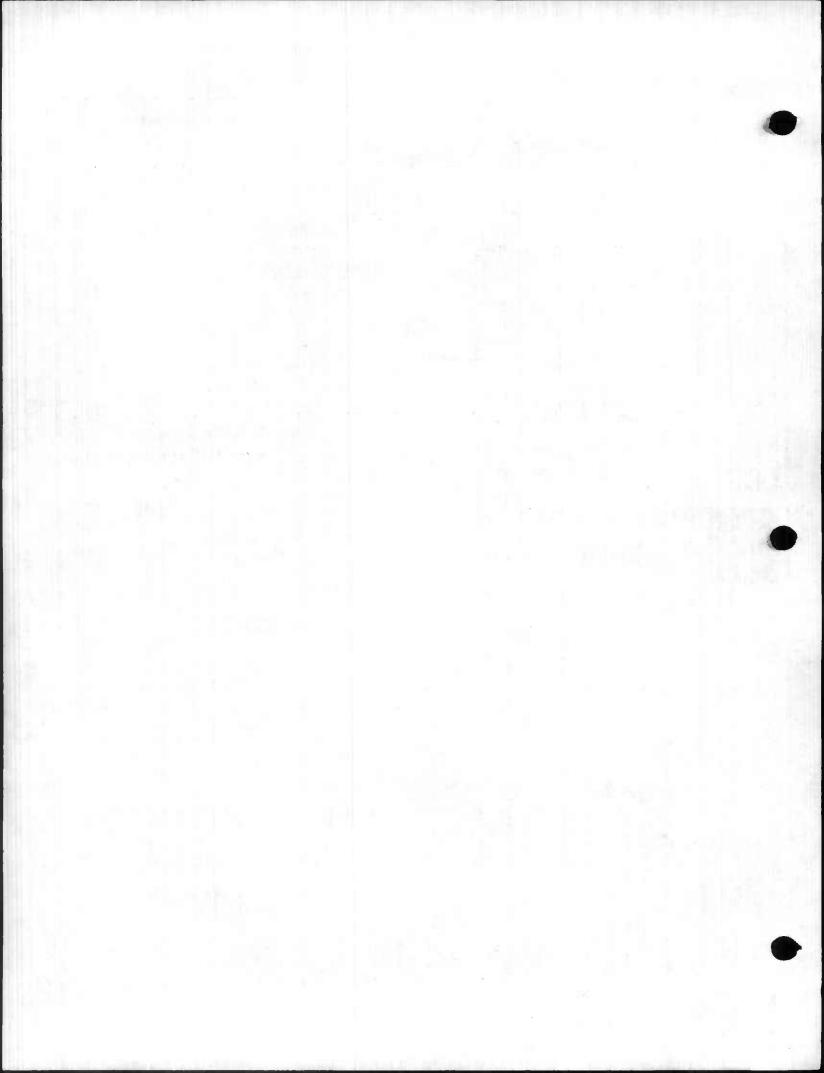
State of Maryland / Department of Health and Mental Hygiene

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/Medical	1 _	LANCE LI									JULY 9				25 P.
Examiner	r 4	la Facility Nama (If not institution, g	rive street ar	nd number)				4	lb. City, Town, or I	ocation of Dea	th 4c. Co	ounty of	Death	
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B 18	-	10a. State	10b. County			10c. Cit	ty, Town or Lo	cation						10d. l	nside City Lin
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or 28e-f e	1	10e. Street and Nu	mber					10f. Zip	Code			10g. Citizer	of Wh	at Country?	
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r Name 234 older mant	1	11. Marital Status		12. Was	Decedent ed Forces?	Ever in U	,S. 13. V	Was Dece	dent of Hi	ispanic Origin? (S In, Mexican, Puert	pecify Yes or N	0- 14.		American I	ndian,
A P			ied 2∑ Married	1 C	Yes 2 XI		- 1	1 🗌 Yes		Specify:	o rican, acc.)		Black,	Whita, atc.	
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other other		17. Father's Name					LENGINE	EER		18. Mother's Nan	ne (First, Middl				. GOV
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th end Mer 7 le marke traumatic To		19a. Informant's N					19b. Mailin	no Address	-	and Number or Ru				ata. Zio Cod	te)
n 27 le marke er traumatie	1	CAROL LIE	·		~,				1757	LL ROAD,		20 -			
125	1	20a. Method of Dis		å		20b. P	Place of Dispo:	sition (Nar	me of	1	Date	1		ity or Town,	
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Department of the partment of	1	21. Signature of Fr	Ineral Service Like	/	D					LDI FUNE	RAL HOM	E. INC			
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nysician Medical xaminer	1	Part1. Enter to shock, or head immediata Cause disease or condition resulting in death)	(Finat	a. PN	EUMON	IA	th. Do not ente	er the mod	de of dyin	HAMPSHIR g, such as cardiad	E AVE.,	STLVE	K S	Api	, MD Z proximate arvai Betweer set and Deati
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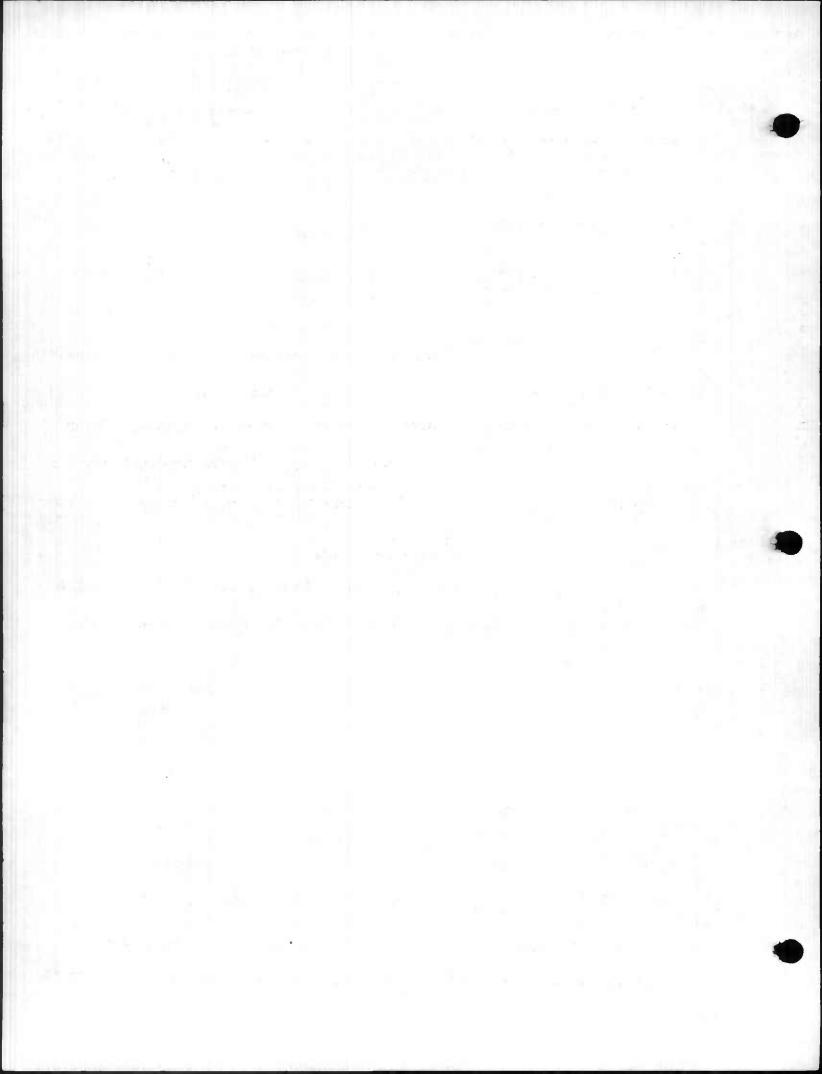
State of Maryland / Department of Health and Mental Hygiene

			Certific	ate of Deat	h	Reg.	No.	20	900
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/Medical	SO TSE				JUI	LY 12	, 1999		:30 PI
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Mand Mand	10a. Stata 10b. County	10c. C	City, Town or Location					10d. In:	side City Limit
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72 hours after death with the Manyland natural, or forms 23a or 28a-f show the Emerican must be notified at steed by Furneral Director	11. Merital Stetus 1 Never Married 2 Merried 3 Myldowed 4 Divorced	I2. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:		ecedent of Hispanic of Specify Cuben, Mexicos 2X No Specify		or No-		American Ind Vhite, atc. Asial	
c * # ~	15. Decedent's Educ (Specify only highest grade Elementary/Secondery (0-12) 12th	cation completed) College (1-4or 5+)	life. DO NO	Isual Occupation work done during m T use retired) OUSEWife	ost of working	16b	. Kind of Busine		
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T Hear Other	20a. Method of Disposition		Plece of Disposition (Neme of	Dete		Location - City		
Pages nent of rut: If littery or o	Buriel 2 Cremetion 3 Red 4 Donetlon 5 Other (Specify)	emovel from Stete	cemetery, cremetory		m. 7/15/	99 5	ilver	Sprin	na Mi
pemit. Pa Departmen Important: any Injury pacs.	21. Sign e 1 Funeral Service Li n		22. Nemo SNC	end Address of Fed WDEN FU	NERAL HO	ME,		DATT	ilg, III
	23a Part I Enter the dispass or compile	alions that saying the day		CKVILLE,				Appr	oximate
Physician /Medical Examiner	23a. Part1. Enter the fisseese, or complishook, or hear feilure. List only on timmediete Cause (Finel disease or condition resulting in deeth) a								vel Between of end Deeth
rificate be executed ng physician and est the burial-transit Medical Examiner	Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to ((or es a consequence	of):				one	da
at the death cerd by the attendin etached for use Physician/N	4							-	
e dea the at hed fc	Part ti. Other significant conditions con	tributing to death but not re	sulting in the underlying	ng cause given in Pe	rt I. 23	b. Did tobac	co use contrib	bute to the c	ause of deat
es that the igned by be detacl by Phy						1 🗆 Yes	No 30	Probably	4 Unkno
s been s 2 should pleted					248	. Was en au performed		available	on of cause
The ta						1 Ves	2.00	1 🗆 Yes	2□ No
ysicien: The s certificate director, pag To Be Col	25. Was case referred to medical examiner?				ace of Death (Check	only one)			
7 00	10 162 2/2/10	I THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN			Nursing Home 5	-		Specify)	
After fune	27. Menner of Death 1 Neturel 5 Panding 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2		scribe how in	njury occurred		
tal or Atland is after deatl al Director: led in by the Certifical	4 Homicide determined	28e. Plece of thiury - At building, etc. (Spec		tory, office	281. Loc City	ation (Street or Town, St	t and Number o fete)	or Rural Roul	te Number,
To the Hospital of within 24 hours at To the Funeral D completely filled in Medical Ce	29e. Certifier (Check only one) 1 Certifying Physical Examin	ician: To the best of my kn er: On the basis of examin and manner steted.	owledge, deeth occur etion and/or investige	red at the time, dete tion, in my opinion, d	and plece, end due leeth occurred at the	to the cause time, dete	end pisce, and	er as stated. due to the c	euse(s)
To the comp	29b. Signeture and title of certifier	Chion	mb	29c. License numbe			Dete signed (M		
1	30. Name and address of person who con H. Victor chiang	mpleted cause of death (Ite	om 23a) (Type, Print) Tedical Ce	enter Dr.	Suite 32	OR	veltvill	my	2080
State	31. Date filed (Month, Day, Year)	32. Registrer's Sign	nature	1 .		1	-1		



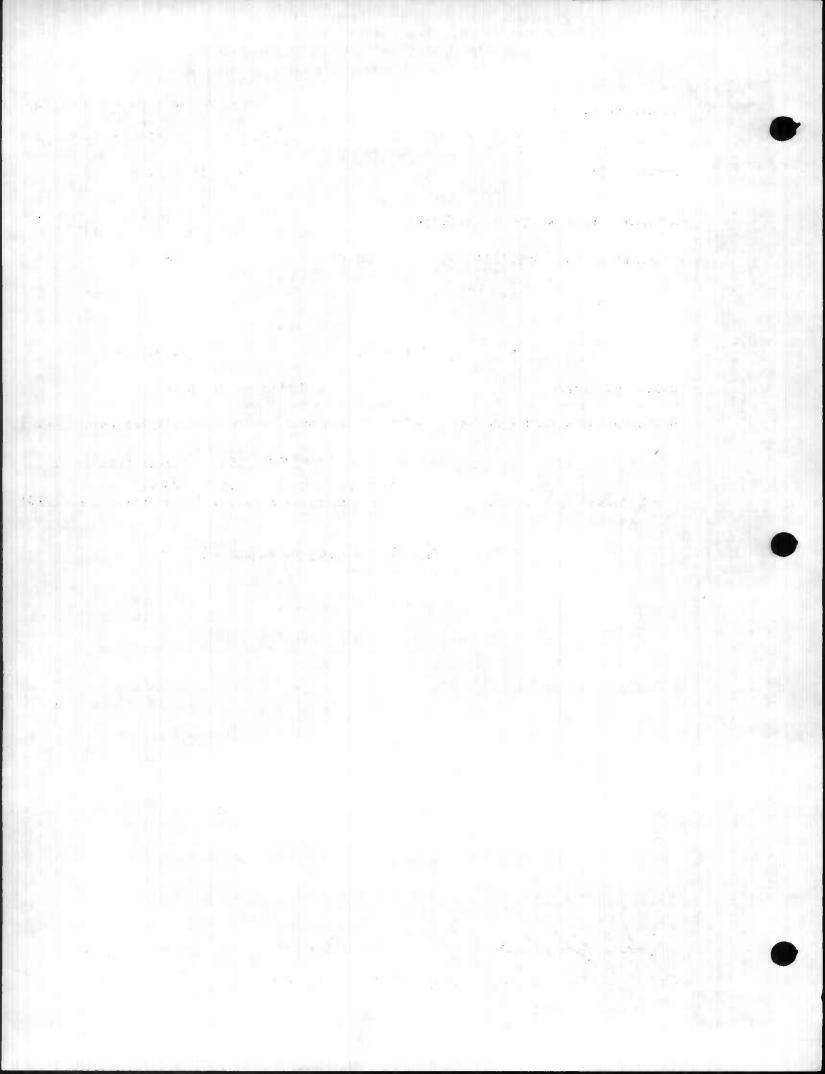
State of Maryland / Department of Health and Mental Hygiene

					Certificate of		R	eg. No.	23504
	Physic		1. Decedent's Nama (First, Middla, Last) Ethel Rickert	Low			2. Data of Deet	Day 19	(ear) 9:30 pm
	/Medi Examii		4e. Facility Nama (If not institution, give street and n	umbari	1	4b. City, Town, or L	ocation of aeth	4c. County of	Death
-	Francist	H	Doctors Community 5. Social Security Number 6. Sex	7. Aga (In yrs. last bir		Lanha If Undar 24 Hrs.			Georges
	Funeral Director		064-07-0305 Usual Rasidence of Decedent		Yrs. Months Days		8. Deta of Birth (Month, Day, May 6, 1		D. Birthplaca (Stata or Foreign Country) New Jersey
	Manyland -f show	_	10a. Stata 10b. County	10c. City, Tow	n or Location				10d. Insida City Limits
	the Marylan r 28a-f show	Funeral Director	Maryland Prince George'	s Hyat	tsville				1 ☐ Yas 2 ☑ No
	th with	i Di	5609 37th Avenue		10f. Zip Coda	782	1	0g. Citizen of Wh	at Country?
	ter deati	ner		cedent Ever In U.S.	13. Was Decedant of If Yas, specify Cub		ecify Yes or No-		Amarican Indian,
5-0020	B 0 E	þ		2∰ No iiva	1 ☐ Yas 2½ No		most, etc.)	Specify:	White
15-0	72	Completed	15. Decedant's Education (Specity only highast grada completed) 16e.	Dacedant's Usual Occu (Giva kind of work done lifa. DO NOT usa retire	pation during most of work	ring	16b. Kind of Busi	
2121	filed within Hygiene. ther than " int, the Mer	omp	Elamantary/Secondary (0-12) College 12	(1-4or 5+)	iiia. <i>DO NOT</i> usa retira Ministrativ	•		Fodoro1	Government
	be filed tal Hygid d other event, II	BeC	17. Fathar's Nama (First, Middla, Last)	1101	MINISCIACIV	18. Mother's Nam			
Maryland	should by a Menta marked matic ev	5	Charles George Rickert				Schill		
Ma	2 2 2		19e. Informant's Name/Ralationship (Type, Print) Edward F. Low (husb		. Mailing Address (Stree			,	
ore,	of Health Hem 27 other t		20a. Method of Disposition	20b. Placa of	09 37th Aven Disposition (Name of my, crematory or other pla	-			d 20782 ity or Town, Stata
altimore,	Page ment o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	Lincoln Ceme	-	7/14/99	Brentwoo	d.Marvland
Ball	permit. Page Department of Important: If I any injury or once.		21. Signature of Funeral Sarvice Licensee		22. Nema and Addre Francis J	ass of Facility			
2/_	202 4 4		23a Part Fater the disease or complications that	could the death Do	500 Univer	sity Blv	1WSi	lver Spr	ing,MD 20901
	Physician		23a. Part1. Extar the disaasa, or complications that shock, or haart tailure. List only ona causa on	aech line.	not entar tha mode of dy	ng, such as cardiec	or raspiretory erre	981,	Approximete Intarval Batween Onsat end Deeth
궦	/Medical Examiner		Immediate Ceusa (Final disaasa or condition	Cardio	pulmona	y Cerr	est		-
	Lxammer	Pe.	rasulting In daath) a	Dua to (or as a	pulmona point of the consequence of: 4 Hero se	/ _	4.5		10.
	outed and rensit	Examiner	Sequentially list conditions	Acute 10	150 ca rola ((つ たんへ	tron		12 hrs
90,	cate be executed physician end the burial-trensit		Sequentially list conditions, if any, leading to immediate causa. Entar Undartying Causa (Disease or injury c.	Sovere V	4therose	lesotic	bleart	Diseas	L Years
09289	death certificate be executed e attending physician and sd for use as the burial-trensi	edicai	that initieted evants rasulting in daath) Last	Due to (or as a c	consequenca of):				
Box	attending for use as	5	d						
	the atte	Physician/	Part II. Other eignificant conditions contributing to c	leath but not resulting in	n tha undarlying causa gi	van in Part I.	23b. Did to	bacco use contr	ibute to the cause of death?
P.0	es that the designed by the a be detached f						1 🗆 Ye	2 X No 3	Probably 4 Unknown
Records,	law requires that the as been signed by the 2 should be detache	d by					24a. Was ar	neutopsy	24b. Were autopsy findings
000	aw requires been si	Completed					perform		evallable prior to completion of cause of death?
	The law ate has page 2	Com					1□ Ya	s 2 No	1 Yas 2 No
of Vital	Physician: The	Be	25. Was case referred to medical examiner?			26. Pleca of Deat			
o	Phys r this eral di	1: To	TEL 462 STRING	¶npatient 2 ☐ ER/Ou of Injury 28b. T nth, Day Year) II	tpatient 3□ DOA		ma 5 Rasida 28d. Describe ho		
ion	Attending or death. ector: After by the fune	ation	2 Accidant Invastigation	nth, Day Year) II	njury Wo	rk? Yes 2 □ No			
Division	s after de il Directo ad in by th	Certification:	3 Sulcida 6 Could not be datarmined 28a. Place build	e of Injury - At homa, fei ing, etc. (Specity)	rm, straat, factory, offica		28f. Location (Str City or Town	reat and Number , Stata)	or Rural Routa Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page	edicai (29a. Cartifiar (Check only one) Check only one) Check only 2 Medical Examiner: On the band mar	a best of my knowledge, easis of axamination and mar stated.	, daath occurred et tha ti d/or invastigation, in my o	ma, data and piece, opinion, daath occur	and dua to the ca red at tha tima, da	usa(s) and mann ite and place, and	er as stated. d due to tha cause(s)
	To th To th comp	Me	29b. Signetura and title of certifiar		29c. Licens				Month, Day, Year)
	10		30. Nama and addrass of person who completed cau Stephanic Trifuglio		D	37934	-	7/11/	99
			30. Nama and addrass of person who completed cau	sa of death (Item 23a) (Type, Print)	Certer Dr	le Cores	en bot	4D 20770
	Sta	te	31. Data filad (Month, Day, Year) 32.5	Registrer's Signature	4 /				



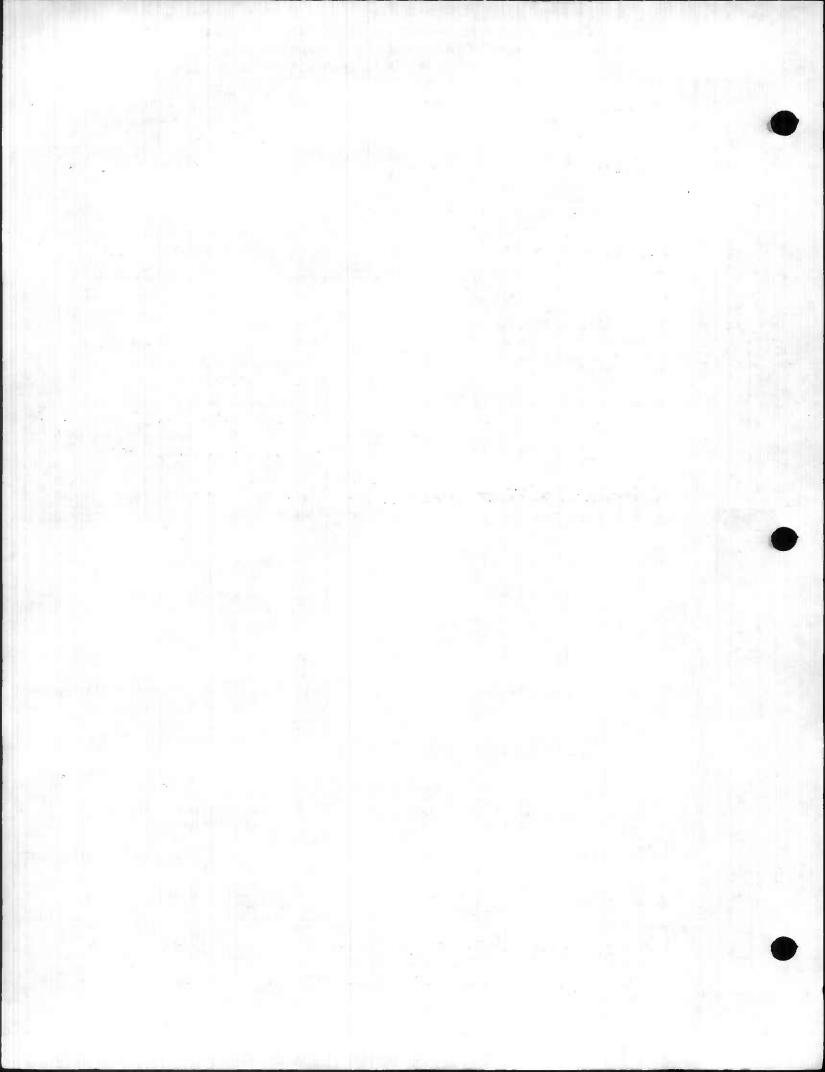
State of Maryland / Department of Health and Mental Hygiene

					0.0.0 0, 10	ai y iai i		ertificate o	f Death		Reg. No.	2 4	. outo
	Discostati		1. Decedent's Nam	e (First, Middle, La	est)					2. Data of De		Year	3. Time of Death
	Physicia Medic/		Daniel T	. Martin						July	8 /	999	1005 AM
	Examin	-		9	ra street end number)		_		4b. City, Town, or I	ocation of Deat	///		11 6
		.8	790KK		ed April	. 4	ニス		Ade	1 phe		ACC	beorges
	Funeral		5. Social Security N		Sex 7. A⊊ 15⊋M 2□F	ge (In yrs.		Lingtha Day		(Month, De	th y, Year)	9. Birth	place (State or Foreign ntry)
	Director		215-36-4 Usuai Residence of	213	Q EU		60 Yrs			July 2	0,1938		DC
	and w		10a. Stete	10b. County		10c. Cit	y, Town o	r Location					10d. Inside City Limits
	f aho	ŏ	Maryland	Prince G	orgo!c	Adel	nhi						1 ☐ Yes 2 ☑ No
	the 28s	Director	10e. Street and Nur		eoige s	Auc.	LPIII	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	ier death with the Marylan Rems 23a or 28a-f show ner mast be notified at		7001 D D4	non Dood	A to 207						USA		
	me 2	Funeral	7901-R Ri	ggs koad	12. Was Decedent		S.	20783 13. Was Decedent of	f Hispanic Origin? (Suban, Maxican, Puart	pecify Yas or No			can Indian,
0	or he		1 Nevar Marri	ied 2 Married	Armed Forces?					o Rican, atc.)		ck, Whita,	
07	72 hours after death with the Maryland natural', or items 23e or 25e-f show sical Examiner must be notified at	by	3 Widowed	4 Divorced	If Yes, Give Year or Dates:			1 □ Yas 2 □XN	o Specify:		Specif	γ: W.Π	ite
5-0	natural,	Completed	(Spec	15. Decedent's E	ducetion eds completed)		16a. De	ecedent's Usuel Occ	supetion ne during most of wor red)	kina	16b. Kind of B	usiness/Ir	dustry
21215-0020	within ene. then	du	Elamantary/Seco		College (1-4or	5+)			red)				
2	TI TO 4	S			4		Phys	sicist	T		Aerospa		
Maryland	2 E D	Be	17. Father's Name)				18. Mother's Ner			ne)	
Ž	should be and Mental marked urratic ev	P	Daniel W				T			ne E. A			
Ma	0 0 0		19a. Informant's Na					and the second of the second o	et end Number or Ru				
	fealth 2		20e. Method of Dist		tin / Moth			ob New Hall isposition (Neme of		enue, S	20c. Location		, MD 20903
Baltimore,	90 = 9		1 De Burial 2	□Cremation 3 □	Removel from State	C	emetery,	cremetory or other p	elece)	July 12			
	permit. Pege Department of Important: If any injury or ance.		4 ∐Donation 21. Signature of Fu	5 Other (Special Line)	**	Ga	ce oi	22. Nama and Ado	Cemetery	1999	Silver	Spri	ng, MD
Ba	permit. P Departme Importan any injur		L A	- (1				J. Collins	Funera	1 Home,	Inc.	
1		_	apr	15 Se	Noole	No dead	- Do not	500 Unive	ersity Blv	d. W. S	ilver S	oring	, MD 20901 Approximate
			shock, or hea	rt feilure. List only	plications that ceuse one ceuse on eech li	ne.	1. DO HOL	enter tha moda of d	lying, such as cerolac	or respiratory e	ilest,	1	Interval Between Onsat and Death
	Physician /Medical		immediate Cause ((Final	1 4		0 -	t. 0	400	/ >		1	
	Examiner		disaasa or conditio resulting in death)	in	a. Arceri				to vas cu	ar D	is eas e	-	
		ē				Due to (d	r es a cor	sequence of):				[
	be executed sician and burial-transit	edical Examiner	Cognostially list on	nditions C	b	Due to (o	ras e cor	sequence of):				1	
o o	an an rial-tr	EX	Sequentially list con it any, leeding to im- ceuse. Enter Unde Ceuse (Disease or	nmediete orlying		0 20 ,0 (0							
68760,	ifficate be executed g physician and es the burial-transit	cal	Ceuse (Diseese or that initiated events rasulting in death) i		C	Due to (o	r as a con	sequence of):				-	
	2 0 0	- 1	resouring in country	Last								1	
Вох	es that the death cer igned by the attendin be deteched for use	Physician/N			d								
0	e des	/slc	Part II. Other signif	icant conditions	contributing to death b	out not res	ulting in th	e underlying ceuse	given in Part f.	23b. Did	tobacco use co	ntribute (to the cause of death?
D	that the	F								1 🗆	Yss 2□ No	3 Pro	bably 4 Unknown
S,	signe d be d	l by								04-144-		04h 14	/ere autopsy findings
Record	v requires been sign should be	etec									an autopsy omed?	a	vailable prior to
Sec	has b	Completed									70 PATE	Of	ompletion of cause death?
<u></u>	cate ha									10	Yes 2 No	1 1	Yes 2 No
Vital	ysician: The	Be	25. Was case refer examiner?		Hospital:				26. Place of Dea	ath (Check only	one)		
0	this al di	٦.	1 XYes 2 ☐ 27. Manner of Deat		1 Inpati		ER/Outpe	Itient 3L DOA		-	dence 6 Oth		ify)
u _C	After funer	E C	1 X Netural	5 Pending investigatio	28a. Date of inju (Month, De	y Year)	28b. Tim Inju	ry W	vork? □ Yes 2 □ No	200. Describe	now injury occu	1160	
S	Attending ir death. sctor: After by the fune	Ilca	2 ☐ Accident 3 ☐ Suicide	6 Could not b	e one Diese of In-	iurv - At ho	me farm	, street, factory, offic		28f. Location	Street end Num	ber or Rui	ral Routa Number,
Division	after Direction of the	Certification:	4 Homicide	determined	building, et			, 011001, 120101, 1, 01110		City or To	wn, Stete)		
	Hospital 24 hours a Funeral tely filled	alC	29e. Certifier	1 Certifying Ph	nysician: To the best	of my kno	wledge, d	eath occurred at the	time, date and place	, and due to the	ceuse(s) and m	anner es	stated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one)		miner: On the basis o and menner st	f examine							
	withii To the comp	X	29b. Signature and	title of certifiar					nsa number		29d. Date sign	ed (Month	, Day, Year)
	20		And	Likes	ANDO			PI	1804		July	12,	1999
	00	ŀ	30. Name and addr	ess of person who	completed ceuse of o	death (item	23a) (Ty	pe, Print)	/		M	1	
_			SAI SU	vster:	DO 3001	Hos	Pit	tal Dr.	ve Che	verly,	Mary	and	(20785
	Stat		31. Date flied (Mon		32. Registr	er's Signa	ture						
	Registra	ar	JU	L 1 3 199	Jy Jen		D	· sport	2				



			Marylano		ificate of	lealth and N Death		Reg. No.		3506
Physician	Decedent's Neme (First, Middle,	Last)	1455	T			2. Dete of De Month	Dey	Yeer	3. Time of Death
/Medical	BESSIE 4a Facility Nama (If not institution,	nive street and numb		ERRICK		4b. City, Town, or L	JULY 1		of Dooth	1:15 PM
Examiner	LAYHILL ELDER		0.7				SPRING		GOMERY	Y
Funeral	5. Social Security Number		Age (In yrs. las		If Under 1 Yeer Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir	th Year)	9. Birthpla	ace (State or Foreign
Director	218-66-6423	1□ M 2√2 F	9	6 Yrs.	WOULD DOYS	TIOUIS WITH	SEPT.	11, 1902	2 WAS	HINGTON, DO
1	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	tion				100	d. Inside City Limita
Mentel thygiene. arted other than "natural", or hams 23a or 28a-1 show sets avent, the Medical Examinar must be notified at To Be Completed by Funeral Director	MARYLAND MONTO	GOMERY	SIL	VER SP	RING					1⊠Yes 2□No
be notified Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Whet Countr	γ?
23a c	3227 BEL PRE F	ROAD			209	06		UNITED	STATES	3
item 27 le marked other than "natural", or farma 28 or 28s-l'elrem other treumatic avent, tra Maddal Esaminar must la notified at To Be Completed by Funeral Director	11. Merital Status 1 □ Never Married 2 □ Merrie 3 ☒ Widowed 4 □ Divorced	12. Wes Decede Armed Force d 1 Yes 2 If Yes, Give Year or Dete	AS? INO		es Decedeni of he'es, specify Cub. Yes 2M No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	e - Americai ck, White, at v: WH]	tc.
acal acad	15. Decedent's (Specify only highest	Education		16a. Deceder	nt's Usuel Occup	pation during most of work	kina	16b. Kind of Bo	usiness/Indu	istry
nt, tre Medical of Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	HOUSE	NOT use retired	d)		OFT	N HOMI	F
A. O.	12 17. Father's Name (First, Middle, Li	ast)		HOUSE	WILE	18. Mother's Nem	A (First Middle			
o Be	JACOB SHERMAN	/				JENNY	(UNKNOV			
To	19a, Informant's Neme/Reletionshi	p (Type, Print)		19b. Meiling	Address (Street	and Number or Ru	ral Route Numb	er, City or Town,	Stete, Zip C	Code)
3	JERRY S. MEDERI	RICK (SON)	14801	PENNFIE	LD CIRCLE	E-SILVE	R SPRING	, MARY	YLAND 2090
once.	20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spe		cen		ion (Name of tory or other ple OM TALMU		Date / 14/99	20c. Location - WASHING		
BUCE	21. Signature of Funeral Service Li	Statte		E 11	70 ROCK	ess of Facility -GOLDBERG VILLE PIK	KE-ROCKY	VILLE, M		
cian	23a. Part1. Enter the disease, or c shock, or heart feilure. List or	omptications that cau nly one cause on eed	sed the eath. h line.	Do not enter	the mode of dyir	ng, such as cardiec	or respiratory a	rrest,		Approximate Intervel Between Onset end Deeth
dical niner	Immediate Cause (Finel disease or condition resulting in death)	GAS	TROINTE	ESTINAL	BLEEDI	NG			1 2	2 DAYS
	rosung in coatry		Due to (or e	es a conseque	ence of):				1	
dical Examiner	Sequentially list conditions, if any, teading to immediate	b	Due to (or a	as a conseque	ence of):				1	0
. 6	Sequentially list conditions, if any, teading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or e	es e conseque	nce of):	-				
lan									1	
Physician/M	Part II. Other significant condition	s contributing to deat	h but not resulti	ing In Ihe und	erlying cause giv	ven in Pert I.	1			the cause of death?
by Pt							10	Taa 2∐ No	3 □ Probe	ably 4∑ Unknown
pleted								an autopsy ormed?	avai	re autopsy findings ilable prior to apletion of cause eath?
director, page 2							10	Yes 2 No	10	Yes 27 No
e	25. Was case referred to medical examiner?					26. Place of Dea				
	1 Yes 2 No	Hospital: 1 Inp			3LI DOA			Idence 6 Oth)
tou	27. Manner of Death 1 Natural 5 Pending investigations	28a. Dete of I (Month,	Day Year)	8b. Tima of Injury	Wo M 1	ryet rk? Yes 2 □ No	28d, Describe	how injury occur	700	
Certification:	2 Accident 3 Suicide 4 Homicide	l be 28e, Plece of	Injury - At hom, etc. (Specify)	ne, ferm, stree	I, fectory, office			(Street and Numb wn, Stete)	per or Rural	Route Number,
completely filled in Medical Cer	29e. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the be caminer: On the basis and menner	s of examinetio	edge, death o n and/or inves	ccurred et the ti stigetion, in my c	ma, date and place, opinion, death occur	, and due to the rred at the time,	cause(s) and mi date and place,	anner as sta and dua to t	ited. the cause(a)
W Com	29b. Signeture end title of certifier				29c. Licens	se number		29d. Dete signe	d (Month, D	lay, Year)
	Amend	(mod	O N	W	D382	.62		JULY 14	, 199	9
	30. Nama and address of person w					UITE 340	- ROCK	VILLE, M	ARYLA	ND 20850
State gistrar	31. Date filed (Month, Day, Year) JUL 1	40.00	istrars Signetur		9. po	als				

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death		Reg. No.		1907
Physicia	an	_	ne (First, Middle, Last)						2. Date of Dec Month	Day	Year	3. Time of Death
/Medic		Leonal		Mills					July	13, 19		10:42 AM
Examin	er		(If not institution, give						Location of Death			
			Regional Ho				***	Laurel			e Geo:	-
Funeral Director		5. Social Security 578-12-7	7220 12	M 2□ F 7		last birthday) Yrs.	Months Day			Year) 1919	9. Birthple Countr Washii	ngton, D.C.
ith the Maryland or 28a-f ahow		Usual Residence	10b. County			, Town or Lo					100	d. Inside City Limits
W THE	Director	MD	Prince Ge	orges	Mt.	Raini	er					1 ☑ Yes 2 ☐ No
4 2 2	듬	10e. Street and No					10f. Zip Code			10g. Citizen of V	What Countr	y?
23		4500-32r	d Street				20712			U.S.A.		
72 hours after death with the Maryland natural, or floms 23a or 28a-f ahow dical Examinar must be notified at	by Funeral		ried 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	7		Ves Decedent of Yes, specify Cu	Hispanic Origin? (5 ban, Mexican, Pue o Specify:	Specify Yes or No to Rican, etc.)	Specify	e - America ck, White, et Whi	ic.
	Completed	(Spe			5+)	(Give I	O NOT use retir	e during most of wo	orking	16b. Kind of Br		estry
Hygiene. ther than ant, the		42 February Name	12			Inspe	ctor Fo	7	or of Plant Bridge			
it of Heelth and Mental Hyglene. If Item 27 is marked other than or other treumatic avent, the Me	Be	i/, ramers Name	(First, Middle, Last)						me (First, Middle,		re)	
2 2 2	2	Thomas	R. Mills			1		Annie		gan		
h and Mental 7 is marked o treumatic av			lame/Relationship (Ty					et and Number or R				2008)
Heelth other tr	- }	Sharon 20a. Method of Dir		Daughte	20h P		Sition (Name of	reet, Mt.	Rainie	20c. Location -		n Slate
Department of Heelth Important: If Item 27 any Injury or other ti price.		1 Burial 2	Cremation 3 R 5 Other (Specify)	emoval from State	CE	emetery, cren	Cremato	ry	7-14-99		,	· ·
Department Important: If any injury o		21. Signature of F	iuneral Service License	metil	<u></u>		Name and Add	ress of Facility (Chambers			
		23a, Part1, Enter	the disease, or partipli art failure. List only or	cations that cause	d the death							Approximete Interval Between
nysician Medical xaminer	ner	Immediate Cause disease or condit resulting in death]	on .	SE	bue to (or	ras a conseq	uence of):					Onset and Death
physician and the buriei-transit	al Examiner	Sequentially list of any, leading to it cause. Enter Und Cause (Disease of	rinjury 🕿 o		Due to (or	rea a conseq	uence of):					
attending physician and for use as the burlei-transit	n/Medical	that initiated even resulting in death)		I	Due to (or	as a consequ	ence of):					
d for	5	Part II Other plan	ificent conditions	tribution to doath h	ud met man	deine in the co	dod in a november	riven in Best I	22h Did	lohanan usa an	ntelbute to t	the cause of death?
ed by the detached	Physician/M	Partii Other sign	ificant conditions con	and the control	out not resu	rung in the ur	oenying cause o	gwen in Part I.		Yas 2 No	3 Probe	the cause of death? ably 4 thinknown
a been signed 2 should be de	Completed by	Dias	letes.	nelle	Lu	r			24a. Was perfo	an autopsy med?	avai	e autopsy findings lable prior to spletion of cause eath?
pege 2	E	14	mento	10 5/10-	10				101	res 2 No	10	Yes 2 No
certificate rector, pe	8	25. Was case refe	erred to medical	Velici				26 Place of De	eath (Check only o		1	
	0	examiner?		lospital:	ent 2104	ER/Outpatien	3□ DOA C	Whor	Home 5 ☐ Resid		ar (Spaciful	
6 =	\vdash	27. Manner of Dea	ith	28a. Date of Inju	iry	28b. Time of		ury at ork?	-	now injury occur		
ith.	흹	1 Metural 2 Accident	5 Pending investigation	(Month, De	y rear)	Injury		ork? ⊒Yes 2∐No				
services. Director: After d in by the funs	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In			set, fectory, office	9	28f. Location (3 City or Tox	Street and Numb vn, Stete)	ber or Rural	Route Number,
within 24 hours sn To the Funerel DI completaly filled in	edical	29a. Certifier (Check only one)	1D Centifying Phys 2 Medical Examin	ician: To the best ner: On the basis o and manner st	f examinati	viedga, dealin ion and/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and mo date and place,	anner as sta and due to I	ned. the cause(s)
To the	ž	29b. Signature and	d title of certifier				29c. Lice	nse number		29d. Date signe	d (Month, D	lay, Year)
10		160	8		=	4		4193	/	July	13	1999
		20. Name and add	ress of person who co	mpleted cause of c	leath (Item	23a) (Type, I	vok'o	1dRf	Whos	ton 1	ID	20907
Stat Registra		31. Date filed (Mon		32. Registr	rar's Signat	ture 4	Ana	1/2/	0 100	, -,		

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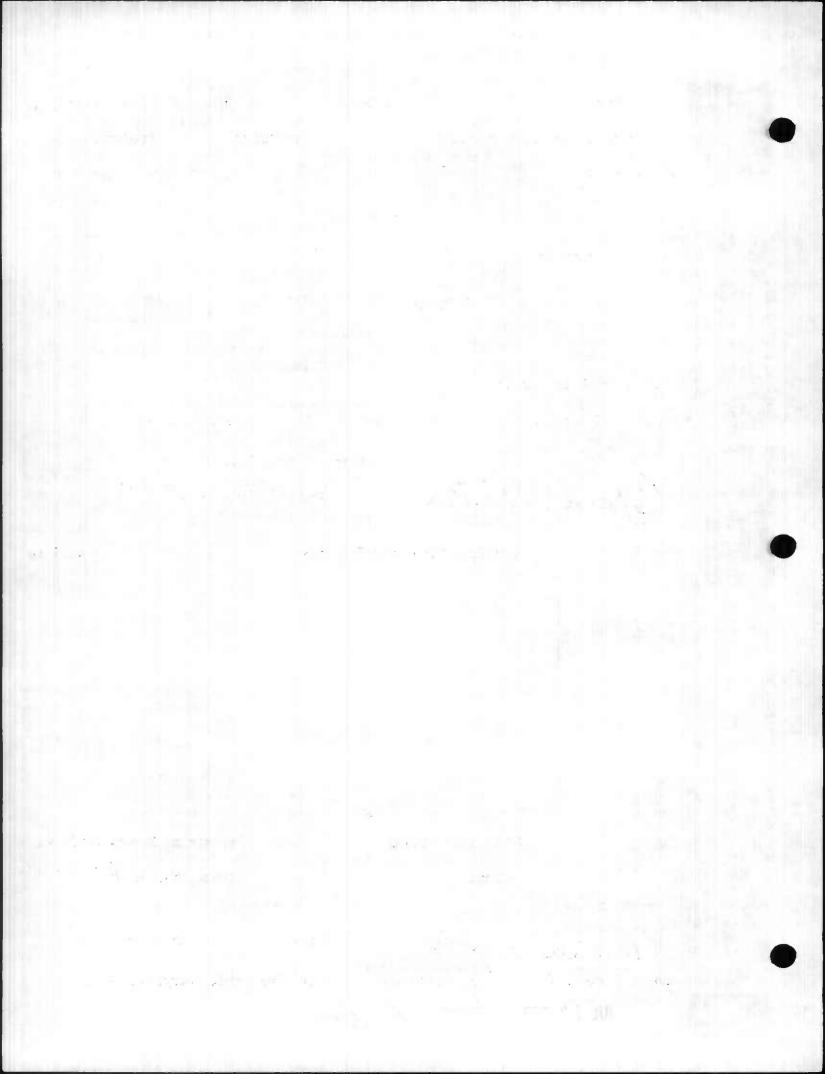
	Decedant's Name (First, Mide	da last		Cen	tificate of	Death	2. Data	Reg. No	0.		3. Tima of Death
Physician /Medical	MINNIE		MORTON				JULY	9, 1	999	Yeer .	11:35 AM
Examiner	4e Facility Nema (If not institution Frederick Memo	_				Frede	wn, or Location of	Deeth 40	c. County	of Death lericl	l _e
uneral rector	5. Social Sacurity Number 401–07–3022	8. Sax 1□ M 2ÅF	7. Age (In yrs. le	st birthday) Yrs.	If Undar 1 Yaer Months Days		Min. 8. Deta	of Birth h, Day, Year mber	,911		aca (Stata or Foreign
	Usual Rasidance of Decedent 10a, Stata 10b, Count	v	10c City	Town or Loc	etion					10	d. Insida City Limits
ō	Maryland Frede			msvill							1 ☐ Yes 2 🕅 No
al Director	10e. Street and Number 10519 Brenda Av	venue			10f. Zip Coda 21754			Unit	itizen of W ted S Amer	Thet Count tates ica	ry? S
by Funeral	11. Marital Status 1 Navar Married 2 Ma	Armed Fo	2 X No va	lf lf	/as Dacedant of I Yas, specify Cub ☐ Yes 2☐XNo	an, Mexican,	gln? (Specify Yes , Puarto Rican, atd	or No-		e - Amarica k, White, e	
led it	15. Deceda	nt's Education	4143.	16a. Decede	ent's Usual Occu	pation		16b. I	Kind of Bu	siness/Ind	ustry
Be Completed	(Spacify only high Elamentary/Secondery (0-12) 12	est grade complated) Collega (1-4or 5+)		ind of work done O NOT use retire .nistrat		of working	Tele	ephon	ie Cor	npany
To Be (17. Fathar's Nama (First, Middle Esadora Whelen	n, Last)					r's Nama (First, M 1 Board	iddle, Malda	n Sumam	a)	
er traumatic event, m To Be Co	19a. Informant's Name/Raiation William L. Mort						NW, Was				
any injury or other traumetic event, trainings. To Be Comp	20e. Method of Disposition 1 ঐ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (State Cer	matary, cram	ition (Nama of atory or other pla Son Cem		July 1	5 Bra	Location - anden ntuck	city or Tou berg	wn, Stata
any injury or page.	21. Signatora of Funaral Sarvice	e Licansaa #MO	0690	Hi	Name and Addra	Funera		Loud	oved 1.1	0 V	antu alar
ician dical	23a. Pert1. Enter the disaasa, shock, or heert failura. Lis	or complications that of st only ona ceuse on e	ausad the death.	Do not enta	r the mode of dy	ing, such as	cardiac or raspiral	ory errast,	SVIII		Approximata Intervat Between Onsat and Death
niner je	rasulting in death)	a	Dua to (or	as a consequ		uma	119				10 loup
prystrain and the buriel-transit	Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury	J	Due to (or	as a consequ	uence of):					1	
ding physicla se as the bur VMedical	that initiated evants rasulting in daath) Lest	d	Due to (or e	es e consequ	ence of):						
atteched for use a	Part II. Other significant condit	ions contributing to d	eath but not result	ting In tha un	darlying causa gi	iven In Part i.	. 23b	. Did tobacc	o uae cor	ntributa to	the cause of death?
be datech	Exten	ZING E	beabi-	tur	VIce	0		1 🗆 Yes	2□ No	3 Prob	Debiy Unknown
should should leted							248.	Was an aut performed?		ava	ore autopsy findings allable prior to appletion of cause death?
pega 2								1 Ves 1	ZXNo -	10	Yes 2□ No
B Be	25. Was case referred to medic examiner?	Hospital: . /				har:	of Death (Check				
E P	1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pend	28a. Data		R/Outpatient 28b. Time of Injury	28c. Inju	4 LI NU		Rasidanca cribe how Inj			/)
Completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could	not be 28a. Place	of Injury - At honing, atc. (Specify)		et, factory, offica		28f. Loca City	tion (Street e or Town, Sta	end Numb ita)	er or Rura	l Routa Number,
To the Funeral Director: After completely filled in by the funer completely filled in by the funer medical Certification:	29a. Certifier (Check only one) Certify Medica	ing Physician: To the il Examiner: On the b and man	best of my know asis of examination ner stated.	ledge, death on and/or inv	occurred at the t estigation, in my	ime, date and opinion, deal	d place, and due t th occurred at the	o the cause(time, date a	(s) and ma	inner as st and due to	ated. the cause(s)
Compo	29b. Signature and title of certifi	er -			29c. Licen	se number		29d. D	ate signe	d (Month, I	Day, Year)
	30. Neme and addrass of person	n who complated cause	sa of death (Itam :	23a) (Type, F	DZ Print) A	1944	7		1/9	74	10.)
	Jan Silver Street Street	CV, 2200	301	000	GTh S	st	Frede	eck,	Md	21	101
State Registrar	31. Dete filed (Month, Day, Yea	7) 32. F	Ragistrar's Signatu	ura L	1						

			Sia	te or ivi	aryland /		ficate o		aith and iv e <i>ath</i>	ленан пу	Reg. No.	22		0.0	U.J.
Physician	1. Decedent's Nam		e, Last)			140	DOMANT			2. Dete of De		7.0 X	sar		
Physician /Medical		loyd				M	ORGAN	1		July	11, Pay			12:4	7 am
Examiner	4a Facility Nama (Frede	orick Me							City, Town, or L Frederic		h 4c.		what Country? S.A. American Indian, k, White Isiness/Industry Spital a) State, Zip Code) 325 City or Town, State ead, MD Home 21798 Approximal Interval Bet Onset and Immedia Immedia 24b. Were autopsy available prior completion of of death? 1 Yes 2 ar (Specify) red uck By Autor Syller, Mer or Ruyal Bouta Num 1911 Frede SVIIIe, Mere Autor Num 1911 Frede		
Funeral Director	5. Social Security N 214-28-0	0031	8. Sex 1 🖾 M 2 [e (In yrs. last b		If Under 1 Ya Months Day		Under 24 Hrs. Hours Min.	8. Data of Bi (Month, Di July 1.	th ay, Year) 5, 19	9.			
fand fand	Usual Residance o 10a. State	10b. County			10c. City, Tox	wn or Local	tion						10	d. Inside (City Limits
Mary Fred the ch	Maryland					Ba1	timore							1K) Ye	s 2 No
or 28s	10e. Street and Nu	ımber			,		10f. Zip Cod	е			10g. Citiz	an of Wha	t Count	ry?	
23a rai [15 W. N	Madison						201							
permit. Peges 1 and 2 should be lifed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, to Maryland Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Marital Status		ied 1 🔀	s Decedent ned Forcas? Yes 2 1 es, Giva		If Y	s Decedent of as, specify C	uban, I	anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)			Whita, a	tc.	
tural tural	3 🗆 Widowed	15. Decedent		Ir or Dates:		a. Deceden	it's Usual Oc	cupatio	n		16b. Kir	nd of Busin			
led within 72 ho tygiene. Nor then "naturn It, tre Medical I	(Special Elemantary/Section 1 (cify only highas ondary (0-12)	st grade comp	lated) lega (1-4or t		(Give kin life. DO	of work do. NOT use rel	ne duri tired)	ng most of work	king					
be liled tal Hyging of other event, I Be Co	17. Fathar's Nama		Last)				PP-J C	-	. Mother'a Nam						
Menta Menta Menta arked artc ev	Lewis I	Frankli	n Morga	an					Sad	die Sta	ub				
aith end 2 27 is me or traums	19a. Informant's N Sandra M.				100		Address (Street			ra <i>i Route Numb</i> tysburg				Code)	
Peges 1 a ent of He nt: If Hem ry or othe		Sposition ☐ Cramation 5 ☐ Other (S)		from State	cemat	ery, cremat	on (Name of tory or other)	place)	Inc.	Date 7 / 1 2 / 9 9					
permit. I Depertm Importar any injui	21. Signator of Fi			1/	ton 1	22. N	lama and Ad	dress d	f Facility Har	rtzler	Funer	al Ho	ome		
10000	23a. Pa II. Enter shock, or has	tha diseese, or art failura. List	complications only one caus	thet caus a on each	the death. Do)4 S. I			Woodsb or respiratory		MD 2		Approxima	etween
Physician // // // // // // // // // // // // //	Immediata Causa disaasa or conditio	on	N	Multip	le Trau	matic	: Inju	ries	3						
Examiner	resulting in death)		a		Dua to (or as a	consequa	ince of):								
icate be executed physician and is the bunel-transit edical Examiner	Sequentially list co if any, leading to in causa. Entar Unde	mmediate	f b		Due to (or as e	conseque	nce of):								
The law requires that the death certificate be exacuted ate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit completed by Physician/Medical Examil	Cause (Disease or that initiated event rasulting In death)	s	c		Dua to (or as a	conseque	nce of):								
atten 3 for u	Red II Other elect	Manna ann dhìa		a to donate to		des Alexander	antine assess		la Dant I	22h Did	Itahaaa		freedom don	the course	of death?
ires thet the death certification is signed by the attending doe detached for use a day Physician/M	Part II. Other signi	mcant conditio	es contributing	g to death b	ut not resulting	in tha unda	ariying causa	givan	n Parti.						
The law requires the state has been signed, page 2 should be of										24a. Was	s an autop ormed?	osy a	con	lable prior	rto
										10	Yos 23	UNo:	1 🗆	Yes 2	□No
ystclan: The law s certificate has t director, page 2 s To Be Compi	25. Was case reference examiner?	rred to medical	Hospital	,					6. Place of Dea	th (Check only	one)				
Physic this correl direction of the correction o	XXYes 2 27. Manner of Dear			1 ☐ Inpatie		Outpatient Time of	3CADOA	Other:	4□ Nursing H	oma 5 Ras 28d. Describe			(Specify)	
ding th. After fune	1 Naturei Accident	5 Pendin	gation Ju	(Month, Da 1110, 1	999 11	55p		njury at Work? I ☐ Yes	2 (No		*		ck B	y Au	to
tal or Attending Physician: rs after death. al Director: After this certificated in by the funeral director, Certification: To Be (3 Sulcida 4 Homicide	6 Could n	not be 28e.		ury - At home, t	-	t, factory, offi	се						•	
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely lilled in by the funeral di Medical Certification: To	29a, Certifier (Check only one)		g Physician: " Examiner: On	To the best	of my knowiedg f axamination a				data and place, on, death occur	and dua to the	cauae(s)	and mann	er as sta	ated.	
To the comp	29b. Signature and	titla of certifia	wZ		24	_	29c. Lic	3516				e signed (i			
	30. Name and addi Andrew Z	rass of person Zarick,	Jr, M					ree	t, Frede	erick,	Mary]	land :	2170	3	
State Registrar	31. Date filed (Mon	JUL 1 2	1999	32. Regietr	ar's Signature	ß.	Spa	eks							

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item #25, Per Phy. State of Maryland / Department of Health and Mental Hygiene 7/14/99, Carroll County, wjl Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Year **Physician** Ju₁y Danie1 5:35 Robert Miller 1999 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** 1 M 2 F 75 577-42-5413 Yrs. Director Pennsylvania Usuei Residence of Decedent death with the Manyland 10a. Stete 10c, Cltv. Town or Location 10d. Inside City Limits r than "natural", or flems 23s or 28s-f ahow the Medical Example; must be notified at 1 Yes 2 No Directo Frederick Union Bridge Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 10610 Renner Rd. 21791 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indian, Black, White, etc. 11. Meritei Status filed within 72 hours aftar 1 🛚 Yes 2 🗆 No
If Yes, Give
Yeer or Detes: 1942-45 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry heating & air Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. owner/operator conditioning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy.
Important: if item 27 is marked othany linjury or other traumatic evant
pote. Zana Fretts Walter Joseph Miller 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Union Bridge, MD 21791 Virginia Miller/ wife 10610 Renner Rd. 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removal from State 7/15/99 nr. Woodsboro, MD Rocky Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Sig ture of Fungal Service Licenses Libertytown, MD 21762 11802 Liberty Rd. 23a. Part1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. Physician LEFT LOWER LORE PNEUMONIA /Medical Immediete Cause (Final diseese or condition resulting in death) Examiner Due to (or es a consequence of): 6 WEEKS MIDNE CEREBRAL ARTERY INFARCT Physician/Medical Examiner The law requires that the death certificate be axecuted attending physician and for use as the burial-tran Sequentially iist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? METASTATIC TRANSITIONAL CELL CANCER 1/2 Yee 2 No 3 Probably 4 Unknown þ OF THE BLADGER 24b. Were autopsy findings aveliable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2121No 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) examiner? Hospitai: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 15 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident

or Attending Physician: death. Director: / 24 hours edical To the Hosp within 24 ho To the Fune completely fi

3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier reffying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) and menner steted.

29b. Signeture and title of certifier

29c. License number D31761 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

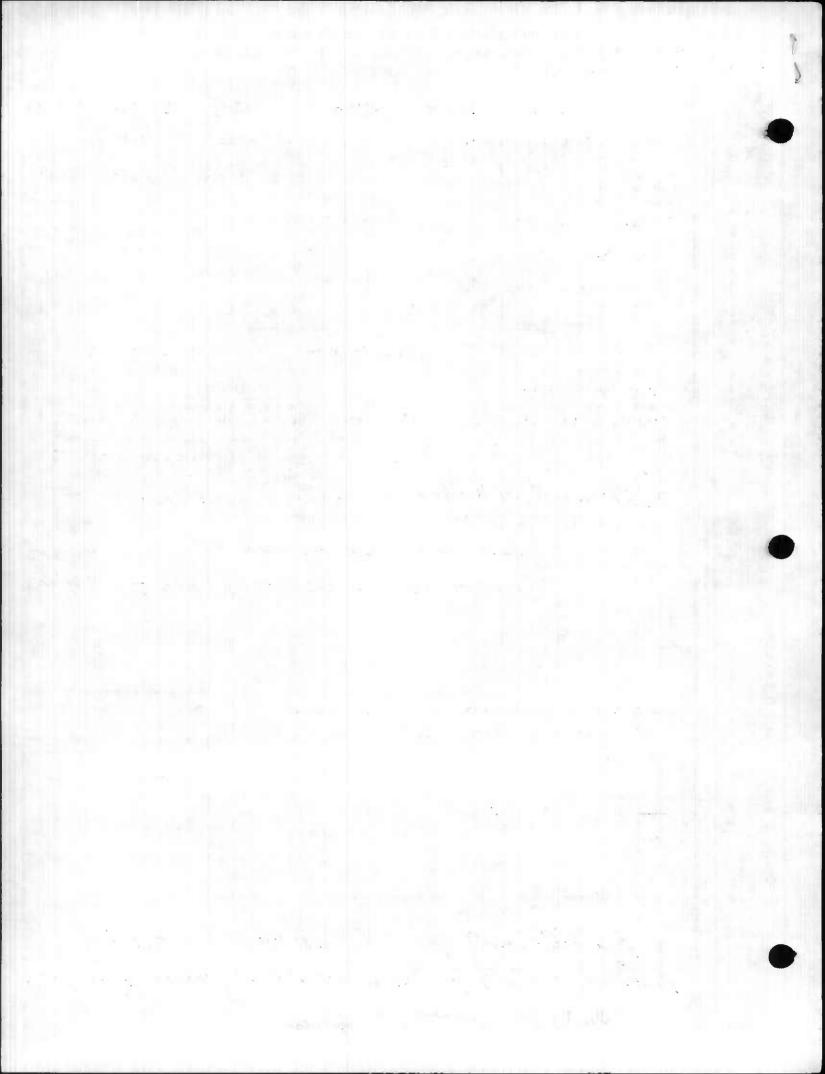
BRITH M. O CONNON MD SOL CV MD

SOU CU, SEVENTH ST, FRENGRICK MD 21701

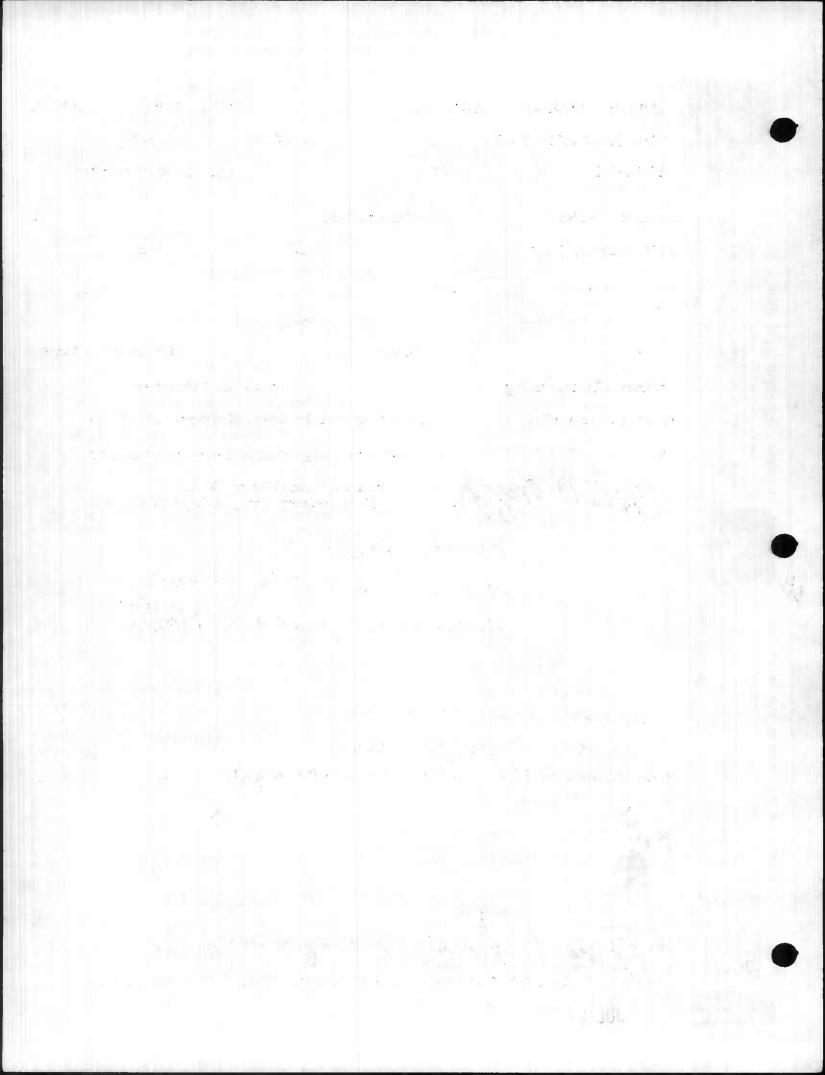
31. Date filed (Month, Dey, Year)

32. Registrar's Signature

State Registrar



			State of I	waryiand /				3	9 2	3511
	Physician /Medical	1. Decedent's Name (First, Michael HERBERT C.		VEY, JR.			Month	Day	Year	3. Time of Death 8:20 PM
	Examiner	4a Facility Nama (If not institut		er)						
	Funeral Director	3466 Churchy 5. Social Security Number 216-14-4513		Age (In yrs. last b	irthday) If Under 1 Yeer Yrs. Montha Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	r, Year)	9. Birthpla	ca (State or Foreign
	pus & s	Usuel Rasidence of Decedant 10e. Stete 10b. Cour	ity	10c. City, Tox	wn or Location				10	d. Inside City Limits
	the Marylan 28a-f show rectled at	Maryland Harf	ford	Abero	deen					1□ Yas 2□No
	iter death with the Ma r Items 23a or 28=4 s increment be results. Funeral Director	10e. Street and Number 3466 Churchvi	lle Road		10f. Zip Code	21001		_		y?
020	by by	11. Marital Status 1 □ Nevar Marriad 2 □ M 3 ☑ Widowed 4 □ Divorce	Armed Force arried 1 ☑ Yas 2 If Yas Give	as?	13. Was Decedent of H It Yes, specify Cub	lispenic Origin? (Sp an, Maxican, Puarto Specify:	ecify Yes or No- Rican, etc.)	Biac	k, Whita, e	tc.
21215-0020	be filed within 72 hor tal Hygiene. d other than "nature event, its Modell Be Completed	15. Deced (Specify only hig. Elementery/Secondary (0-12	ant's Education hest grade completad)) Collega (1-4)	or 5+)		pation during most of work d)	- 1			
	al Hygier that went, the	17. Fethar's Nama (First, Midd							a)	
Maryland	Men Men Men To To	Herbert Clin		10	h Adulian Address (Ctrost				State 7in /	Code)
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Baltimore,	Pages 1 and of Heamont: If Heamont; If Heamont; If Norman Inc. or other	20a. Mathod of Disposition 1 Buriet 2 Cremetio 4 Donation 5 Other		cemati	ary, crematory or other pla		Deta 7/12/99			
Balti	Departm Departm Importa eny Inju	21. Signety 1 of Funeral Sarvi	1) /2011	h.	Maccomac E	unoral Ho	me, P.A	adon M	D 210	na
x 68760,	Cartificate be executed ding physician and se as the burial-transit	Immediate Cause (Finet disaasa or condition resulting in death) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Re a. Lu c. L d.	Dua to (or as a Dua to (or a)	faulus consequence ot): Lich R	station		16		Onset and Daath 9 ylane
. Box	death certific e attending p ed for use as	Part It. Other significant cond	Itlons contributing to deat	h but not rasulting	in the underlying ceuse give	ven in Part I.	23b. Dld t	obacco uee co	ntributs to	the causa of death?
P.O.	requires that the de een signed by the should be detached thould by Physic	sever	e ones	nei	and	11-201	101	res 2□ No	3 Prob	ubly Unknown
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of Vital	Physician: this certific ral director, TO Be (25. Was case ratarred to medi axaminar?	Hospital:	atiant 2□ER/C	Outpatient 3 DOA ON	har	=		ar (Specify)
Division of	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: T	27. Mannar ot Daath 1 Natural 5 Pan 2 Accident Inva 3 Sulcida 6 Cou	ding (Month,	Injury 28b.	Time of Injury Wo	ry at rk?	28d. Describe h	now injury occur Street and Numb	red	
	he Hospita in 24 hours he Funeral plately filled edical C		al Examiner: On the basi	s of axamination a						
	within Toth comp	29b. Signatura and titta of certi	s K	nole	WN May	sa number ylad D	17928	29d. Date signer	d (Month, E	9 9 9
_	2041	James K. Sm	oley, MD, 56	MoVEY, JR. JULY 8, 1999 8:20 I			39			
	State Registrar	31. Date tiled (Month, Day, Yea			B. Some	4				



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MACLEOD			C	ertificate	e of	Death		Reg. No.		235 2
	1. Decedent's Neme (First, Middle,	Last)					2. Date of D		Vana	3. Time of Death
Physician /Medical	David Malcolm	MacLeod					JULY	1, 19	Year 99	10:00P.M
Examiner	4a Facility Nama (If not institution,	give street and number)				4b. City, Town, or	Location of Dea	th 4c. County	of Death	
	ST.AGNES HOSPITA	L				BALTIMO	RE			
Funeral	5. Social Security Number	. Sex 7. Ag 10XM 2□ F	e (In yrs. last birthd	Months	1 Yeer Deys	If Under 24 Hrs Hours Min	. (Month, D		9. Birth	place (State or Foreigntry)
Director	430-76-2653 Usuel Residence of Decedant		J / 118				Feb. 1	6, 1942	Ark	ansas
/land	10a. Stata 10b. County	-	10c. City, Town or	Location					1	10d. fnside City Limits
in after death with the Marylan after death with the Marylan or ferms 23s or 28s-f show refers must be notified at Funeral Director	Maryland Har	ford	Bel	Air						1 ☐ Yas 2♥ No
vith the Me or 28e-f s	10e. Street and Number	LOTA	DOL	10f. Zip	Code			10g. Citizen of	What Cou	ntry?
hwie Gae O le		k Way			2101	L4		Ţ	JSA	
free death v	11. Marital Slatus	12. Was Dacedant Armed Forcas?	Evar in U,S. 1	3. Was Deced	lent of I	dispanic Origin? (S an, Maxican, Puar	Specify Yes or N		ce - Ameri	can Indian,
or he market				1 Yes			to ricall, etc.)	Specif	ck, White,	atc.
D 1 1 0		Yaar or Dataa:	Vietnam	10 100 1	- 124,140	ороспу.		эрөсп	Wh	ite
72 hours	15. Decedent's (Specify only highest)		(G	cedent's Usue iva kind of wor	k done	during most of wo	orking	16b. Kind of B	usiness/In	dustry
1 21215-0020 ed within 72 hours aft yglene. wr than "natural", or rt, tre Medical Exercit, Completed by F	Elementary/Secondary (0-12)	College (1-4or !	5+)	e. DO NOT us Mili				U.S. C	Cover	nment
		est)				-	me (First, Middl	e, Maiden Sumer		IIICIIC
Maryland d 2 should be file th and Mentel Hy 7 is marked othe traumatic event	Transicon Di	chard MacL	eod			Jessie	Mari	on (arne	11
aryla 2 should and Men a mark burnetic	19a. Informant's Name/Relationship	(Type, Print)	19b. M	eiling Addrass	(Street	end Number or R	ure! Route Num	ber, City or Town	, State, Zij	p Code)
and 2 and 2 salth s	Kyo Cha MacLeod	/ Wife	170	1 Beecl	n Ba	ank Way,	Bel Air	MD 210	114	
	20a. Method of Disposition		20b. Place of Di		ne of		Date	20c. Location		own, Stata
Pages nent of nt: If He iry or o	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State	Arlingt	-		1	7-19-99	Trel i nort	rom .	Virginia
三 年春春季	21. Signature of Funeral Service Li	ersee Mag	Julingt			es of Fecility	Iomo D	7	Olly	virginia.
CO E S S S S S S S S S S S S S S S S S S	DH V	K W				esbury Ro			m 21	000
	23a. P. 1. Enter the disee of a case of the case of th	implications that calling	The deeth. Do not					-	בב כוני	Approximate
Physician	stack for heart feiture. List or	lly one beuse on each li	ne.						i	Interval Between 5 Onset and Death
/Medical	Immediate Cause (Final disease or condition	Arterios	ralomtia	Cardio	# 12 C	anlar Di	60360		1	
Examiner	resulting in death)	e Alterios	Due to (or es a con		vas	Curar Di	sease		1	
miner										
and transit	Sequentially list conditions,	0.	Due to (or es a con	sequence of):						
60, be are ician ar burleld	if any, teading to immediate cause. Enter Underlying Cause (Diseasa or injury	C							!	
68760, ificeta be assect g physician and se the burlettra	thet initiated events resulting in death) Last		Due to (or es a con-	sequenca of):					t	
OX 687 certificata nding phys use as tha		d							į	
Boath for the satt										
P.O. that the de detached detached	Pert II. Other eignificant condition	contributing to death b	ut not resulting in th	e underlying c	ause gh	ven in Pert I.		The state of the s		to the cause of death
E 20 -		we pro	lapse				1	Yes 2 No	3 ☐ Pro	obably 4 MUnknov
S 2 2 2			V				24a. Wa	s en autopsy	24b. W	/ere autopsy findings
Record law requir has been s ge 2 should mpleted							per	formed? ECTION	an	vailable prior to ompletion of cause I death?
Rec								IVA MVNA		□Vos 2□ No

Division of Vital

25. Was case referred to medical examiner?

1 Yes 2 No edical Certification: To Be 27. Manner of Death

29a. Certifier (Check only one)

To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pa

15+1

State Registrar

28e. Dete of Injury (Month, Day Year) 1 Naturel 2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Plece of Injury - At home, farm, atreet, fectory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29c. Licensa number 29d. Date aigned (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

29b. Signature and title of cectifier

O.C.M.E.

28c. Injury at Work?

1 ☐ Yaa 2 ☐ No

JULY 2,1999

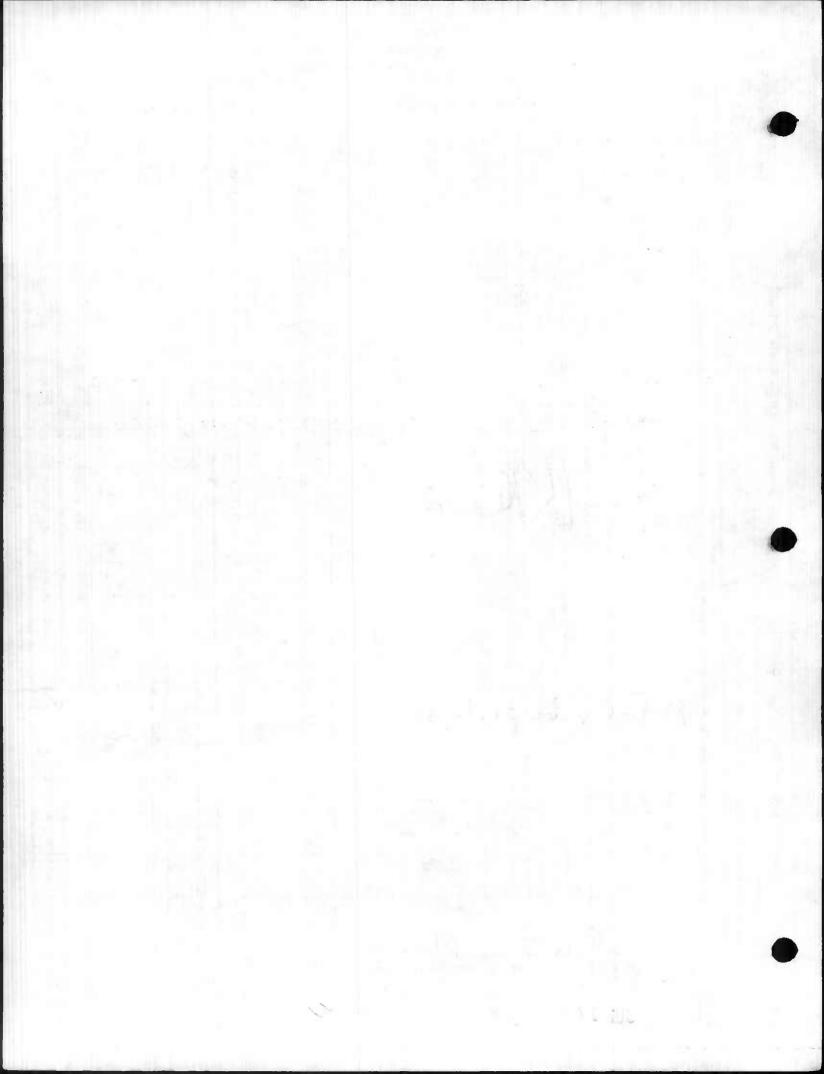
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

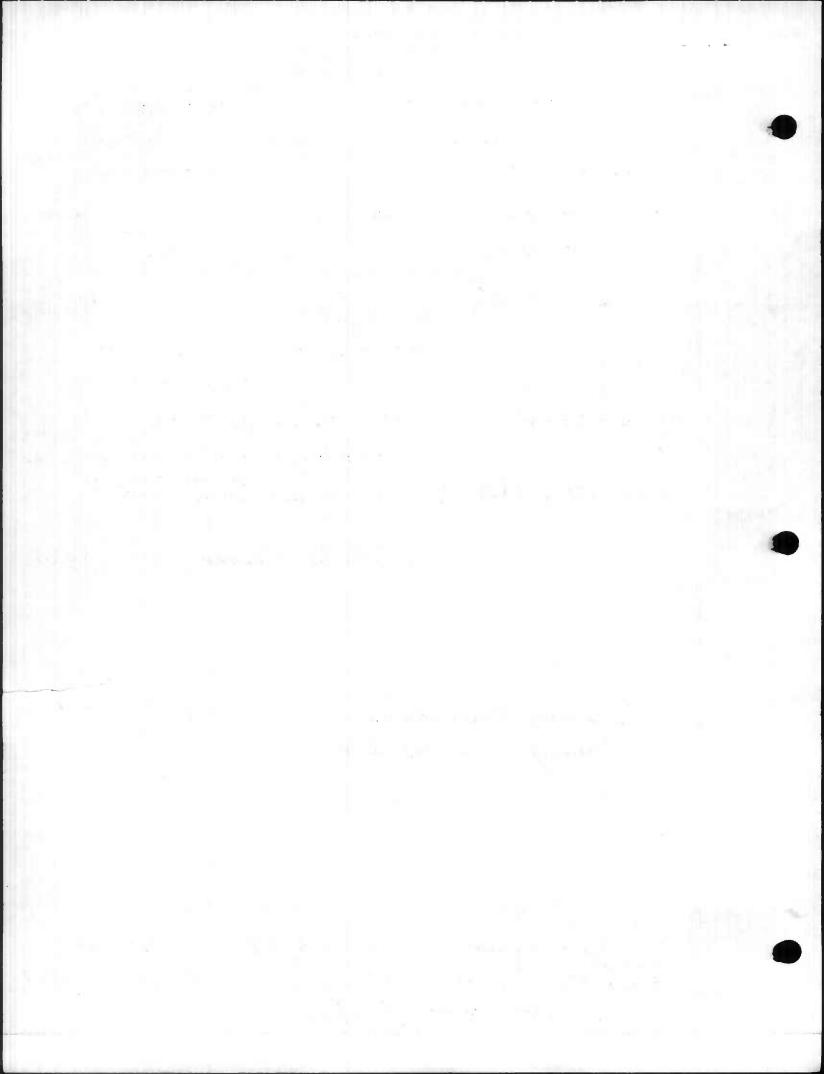
JOSEPH PESTANER M.D. 31. Dete filed (Month, Dey, Year)

JUL 0 7 1999 32. Aegistrer'a Signature

111 Penn Street, Baltimore, Maryland 21201

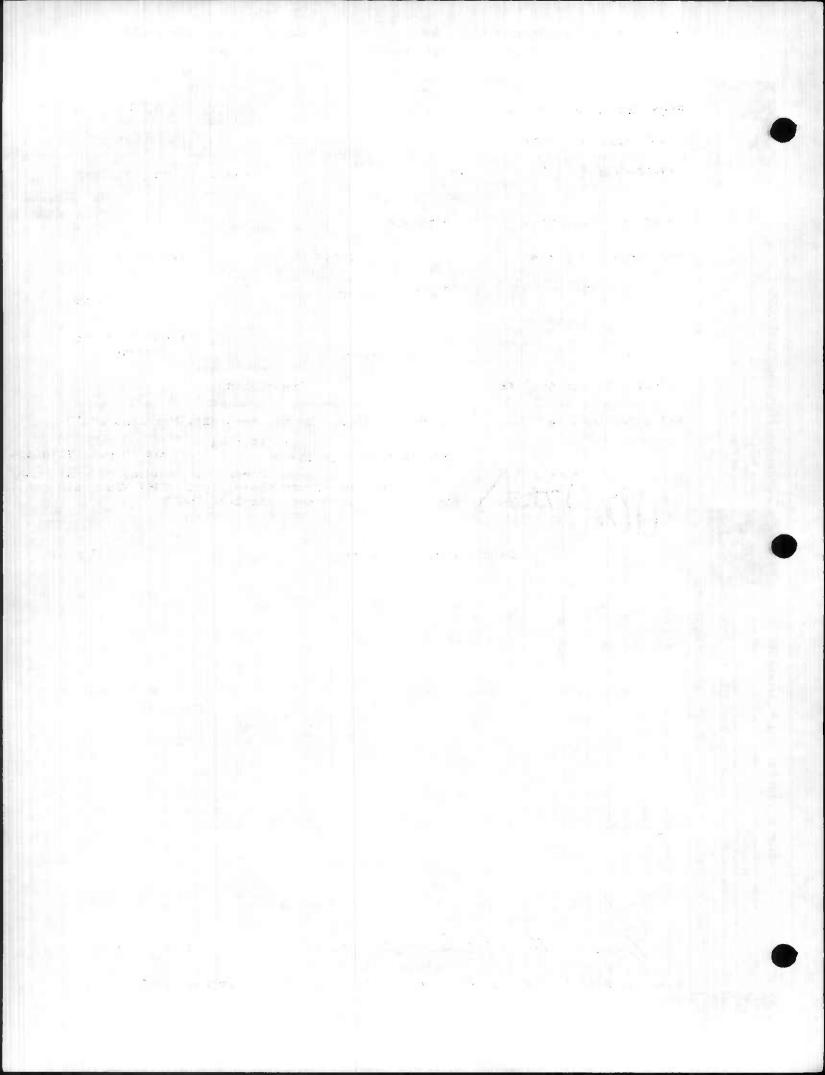


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/Medi Exami		4e. Fecility Neme (If not Institution, gi					4b. City.	. Town, or Lo	ocation of Death			7:50) pm
Exami	ner	Dorchester			ital			nbridg		,	chest	or	
Funeral					. lest birthday,	If Under 1 Ye	ear If Un	der 24 Hrs.	8. Dete of Birtl (Month, Dey				or Forei
Director		213-22 - 6305	1□M 2/5-F	72	Yrs.	Months De	eys Hou	rs Min.	Sept 2	, Year) 5 1926	Mary	ece (State hy) Land	
2		Usuel Residence of Decedent											
ahow	_	MD 10b. County Dorch	nester	10c. C	ity, Town or L		doo				10	d. Inside	City Lim
28a-f ahow	ecto		lester			Cambri							2 ST1
- N	Funeral Director	10e. Street and Number 412. I	Henry St			10f. Zip Cod	de	21613		IOg. Citizen of \U.S.A		lry?	
Items 23a o	eral	11. Meritel Status	12. Was Dece		16 12	Was Doodool	of Missonia		noite Van ar Na		e - America	n Indian	
	5	1 Never Married 2 Married	Armed For	rces?		If Yes, specify (Cuben, Mex	ican, Puerto	ecify Yes or No- Rican, etc.)		ck, White,		
ural', or its	by	3 Widowed 4 Divorced	If Yes, Giv	8		1□Yes 2	No Spec	olfy:		Specify	wh	ite	
natural',	P	15. Decedent's E	ducation		16e. Dece	dent's Usuel Oc	cupation			16b. Kind of B	usiness/Ind	ustry	
	ple	(Specify only highest gr Elementery/Secondary (0-12)	ade completed) College (1	-Aor 5+\	(Give	kind of work do DO NOT use re	one during n stired)	nost of worki	ing				
giene.	Completed	11	Oonege (1	401 54)	food	service	e work	cer		state	hospi	tal	
other vent,	Be	17. Fether's Neme (First, Middle, Las					18. Mc	other's Neme	(First, Middle,	Melden Sumen	10)		
and Mentel I	70	Ralph I	Edward	Murphy				1	Gladys	Madk	ins		
1 ~ = 6		19a. Informant's Name/Relationship							al Route Numbe		Stete, Zip	Code)	
Health Hem 27 other tr		Wayne A. Miller -	son					Cambri	dge, MD	21613			
If he of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from S	State	cametery, cre	osition (Neme o metory or other	place)			20c. Location -			
tant: lury		4 ☐ Donation 5 ☐ Other (Speci	fy)	Eas		Market			-16-99	East N	ew Ma	rket	, Md
Department of Important: If its any injury or of once.		21. Signeture of Funeral Service Lica	10	(1	2. Neme end Ac		T 11.	omas Fu			PA	
				1.1					bridge,				
hysician /Medical		23a. Pert1. Enter the disease, or con shock, or heart feilure. List only Immediate Ceuse (Final	one ceuse on ea	ach line.	ui. Do not en	1 0			mia	651,	i	Approxim Intervel B Onset and	etween
xaminer		diseese or condition resulting in deeth)	θ	Due to (or es e conse		Mc	Mn	mid			34	S
sit.	Examiner	_	b		4						1	0	
ohysician and the burial-transit	хап	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlyin Cause (Disease or injury		Due to (or es a consei	quenca of):							
siciar buri	dical	Cause (Disease or Injury that initiated events	C										
o phy	be	resulting in death) Last		Due to (d	or as a consec	quence of):							
ed by the ettanding p detached for use es	Physician/Me	•	d										
the ett	sicle	Pert II. Other significant conditions	contributing to de	ath but not res	sulting In the u	inderlying cause	given In Pa	art I.	23b. Dld to	obacco use co	ntributa to	the cause	of deg
by th	hy	()	4	1	-0					es 2□No	3 Prob		
5.8	by	Carona	Ny 11	eall	SUS	rease							
been signed by the should be detache		Phin	TI	-	1.0	tin			24e. Wes e		24b. We eve	re autopsy lieble prior	finding
	ple	rilla	y I	ace	ruge	CUON					con	npletion of leath?	cause
s certificate hes b director, page 2 s	Completed								1 🗆 Y	es 25 No	1 🗆	Yes 2	□No
ortifica ctor,	Be	25. Wes case referred to medical exeminer?					26. PI	ece of Deeth	(Check only or	ne)			
this certific ral director,	0	1 ☐ Yes 2 No	Hospital: 1 Kir	patient 2	ER/Outpatie	nt 3 DOA	Other: 4 🗆	Nursing Hor	me 5 Reside	enca 6 □Oth	er (Specify)	
h. After th funera	Ë	27. Menner of Deeth 1 Netural 5 □ Pending	28a. Dete o	f Injury n, Dey Year)	28b. Time o	f 28c. I	njury et Work?	1	28d. Describe h	ow injury occur	red		
or deeth.	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				100	1 Yes 2						
Direct Direct J in by	Certification:	4 Homicide determined	28e. Plece buildin	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, sti fy)	reet, fectory, off	ice	1	28f. Location (S City or Tow	treet and Numb n, Stete)	er or Rural	Route Nu	mber,
within 24 hours after deeth. To the Funeral Director: After this certific complataly filled in by the funeral director,	edical C	29e. Certifier (Check only one) 12 Certifying Pt	nysician: To the la niner: On the ba end mann	sis of examina	owledge, deetl ation end/or In	h occurred at the vestigetion, in m	e time, date ny opinion, d	and place, e	and due to the c ed at the time, d	ause(s) and me lete end plece,	nner as sta and due to	ited. the cause	(s)
Withir To th	X	29b. Signeture end title of cartifier	-			29c. Lic	ense numb	er	2	9d. Dete signe	d (Month, L	Day, Year)	
> F 0		757	melle	all		9	014	340		7/	12/	99	
	-	30. Name and address of person who	20000		n 23e) (Tuno	Print)	- / /.	5 17	Came	//	, 3/,	//	
		or person who	p.otod oddae	(III)	/ 11 Aha!	/	- 1	06	0	/ , /	4 4 -		1
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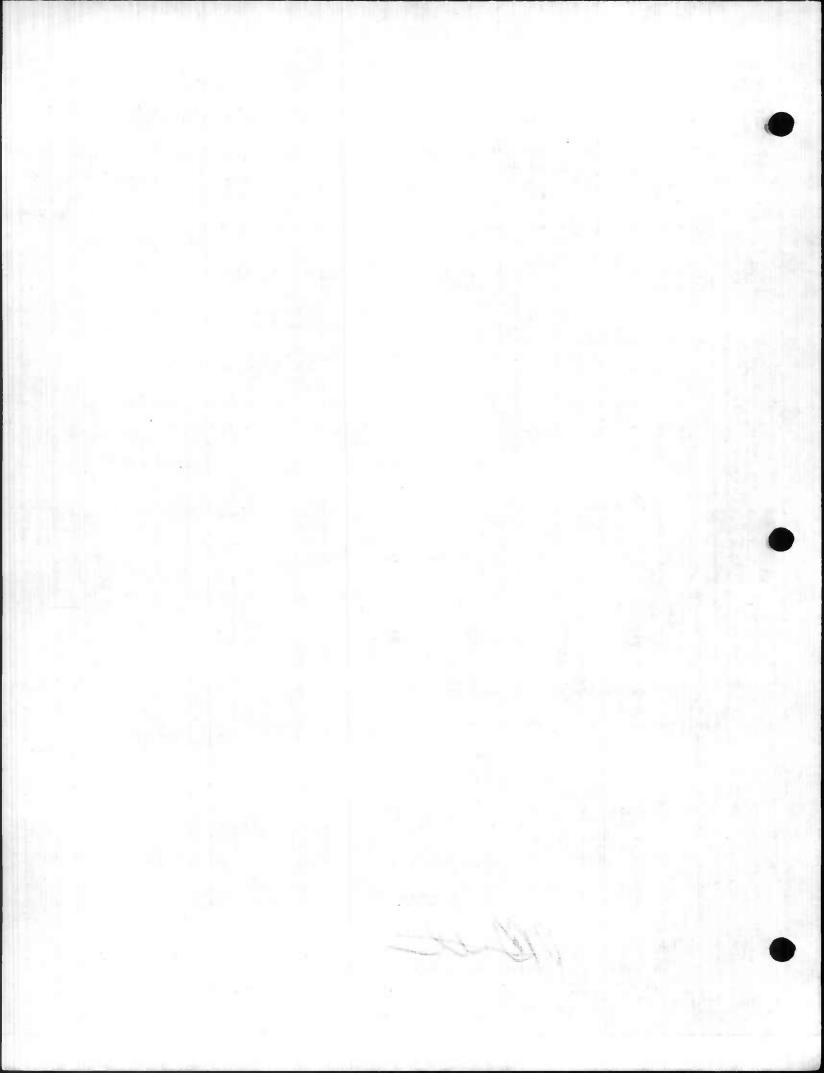
	Decedent's Nama (First, Middla, Last)		0011	ficate of		2. Data of De	Reg. No. ath		3. Time of Death		
ian				Month	Day	Yaar					
al .	Edgar Harrison Newkirk		4b. City, Town, or Lo		12, 199		7:55 AM				
	4a Facility Nama (If not Institution, give street and n	umber)					,				
	9905 Julliard Drive	T		If Undar 1 Yaar	Bethesda			gomer	-		
	5. Social Security Number 447-10-6815 6. Sax 1 1 M 2 □ F	7. Aga (In yrs. las		Months Days	Hours Min.	8. Data of Bir (Month, Da August	y, Year) 3,1922		aca (Stata or Foreign try) Oma		
	Usual Rasidenca of Decedant 10a. Stata 10b. County	10c. City,	Town or Loca	tion				10	Od. Inside City Limits		
Director	Maryland Montgomery					1 ☐ Yas 2 No					
9	10e. Street and Number		hesda	10f. Zip Coda			10g. Citizen of	What Count	Iry?		
9905 Julliard Drive 20817 United 11. Marital Status 12. Was Decedant Evar in U.S. Armed Forcas? 1 Nevar Married 2 Married 12. Was Decedant Evar in U.S. Armed Forcas? 1 Nevar Married 2 Married 1 Nevar Married									0.5		
1	11 Marital Status 12. Was De	cedant Evar in U,S.	13. We		Hispanic Origin? (Spean, Maxican, Puarto	ecify Yas or No		e - Amarica	an Indian,		
	Armed F 1 □ Nevar Married 2 ☑ Married 1 ☑ Yas 3 □ Widowed 4 □ Divorced Yaar or 7 arr or 7 arr or	2□No Worl	ld	Yas 28 No		Hican, alc.)	Specif	ck, White, a	ite		
20.00	15. Decedent's Education		16a. Decedar	nt's Usual Occup	pation		16b. Kind of B	usiness/ind	lustry		
Collibration	(Specify only highast grada complatac	1)	(Giva kir lifa. DC	nd of work dona NOT usa retire	during most of work d)	ing	Light				
	Elamantary/Secondary (0-12) Collega 2				Proprietor			any			
l	17. Fathar's Nama (First, Middla, Last)		TOPII		18. Mother's Name	e (First, Middle,			/ / TEE		
	Edgar Harrison Newkirk				Grace H	atch					
	19a. Informant's Name/Ralationship (Type, Print)	al Routa Numb	er, City or Town	Stata, Zip	Coda)						
	Hilda Mae Newkirk/ Wife				Drive, B						
-	20e, Mathod of Disposition	20h Blo	on of Disposit	ion (Name of		Data	20c. Location				
	1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from 4 ☐ Donation 5 ☐ Othar (Specify)		Browns Chapel Cemetery Browns Chapel Cemetery						l, Virginia		
	21. Signature of Funeral Segular Segul										
	23a. P rt1. En er the di aasa, or complications that slock for hear to ura. List only one cause on	caused tha death. each line.	Do not enter	the mode of dyl	ng, such as cardiac	or raspiretory e	rrest,	1	Approximate Interval Between Onset and Death		
П	Immediate Cause (Finel disease or condition Br	onchogeni	c Carc	inoma					7 months		
	rasulting in death)	Dua to (or a	as a conseque	anca of):				İ			
ine											
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disassa or Injury c.	Dua to (or a	as a consequa	anca of):							
	cause. Enter Underlying Cause (Disease or Injury thet initiated events	D						i			
redical	rasulting in death) Last	Dua to (or a	is a consequa	inca of):							
riiysiciaivm	d							1			
	Part If. Other significant conditions contributing to	van in Part I.	23b. Did tobacco use contribute to the cause of death?								
			1 X Yee 2 No 3 Probebly 4 Unknow								
Completed by						24a. Was	an eutopsy ormed?	avs.	ere autopsy findings allable prior to		
2								of e	mpletion of cause death?		
						10	Yes ZIXNo	10	Yes 2□ No		
	25. Was case referred to medical				26. Place of Deat	th (Check only	one)	1			
0 0	examiner? 1X Yes 2 No Hospital: 1 □	Inpatient 2 El	R/Outpatient	3 DOA Ot	her: 4 Nursing Ho	oma 5 ARasi	danca 6 □Oti	nar (Specif)	y)		
uo:	27. Mennar of Death 1 ☑ Natural 5 ☐ Panding (Mo	a of Injury onth, Day Year)	8b. Tima of Injury	28c. Inju	ry at		how injury occu				
atik	2 Accidant invastigation			M 1	Yas 2□No						
Certification:	3 Suicida 6 Could not be determined 28a. Place	ce of Injury - At hom ding, etc. (Specify)	na, farm, siraa	I, factory, office		28f. Location (City or To		ber or Rura	l Routa Number,		
SalC	29e. Certifiar (Check only 1 Certifying Physician: To the check only 2 Medical Examiner: On the										
Medical	one) and ma	basis of axaminatio	on and/or inva			red at tha tima,					
~	29b. Signatura and titla of certifiar	sa number		29d. Data signe							
	I found At	tolle	mo	D47	791		July 12	, 199	9		
	30. Nama and addrass of person who completed ca	use of death (Itam 2	23a) (Type, Pr	rint)							
	David A. Holden, M.D. 8	09 Veirs	Mill R	oad, Ro	ckville,	Marylan	d 20851				
ite		Registrar's Signetu	ra L	1							
strar	JUL 1 3 1999	Eleva	17	DOOLK							

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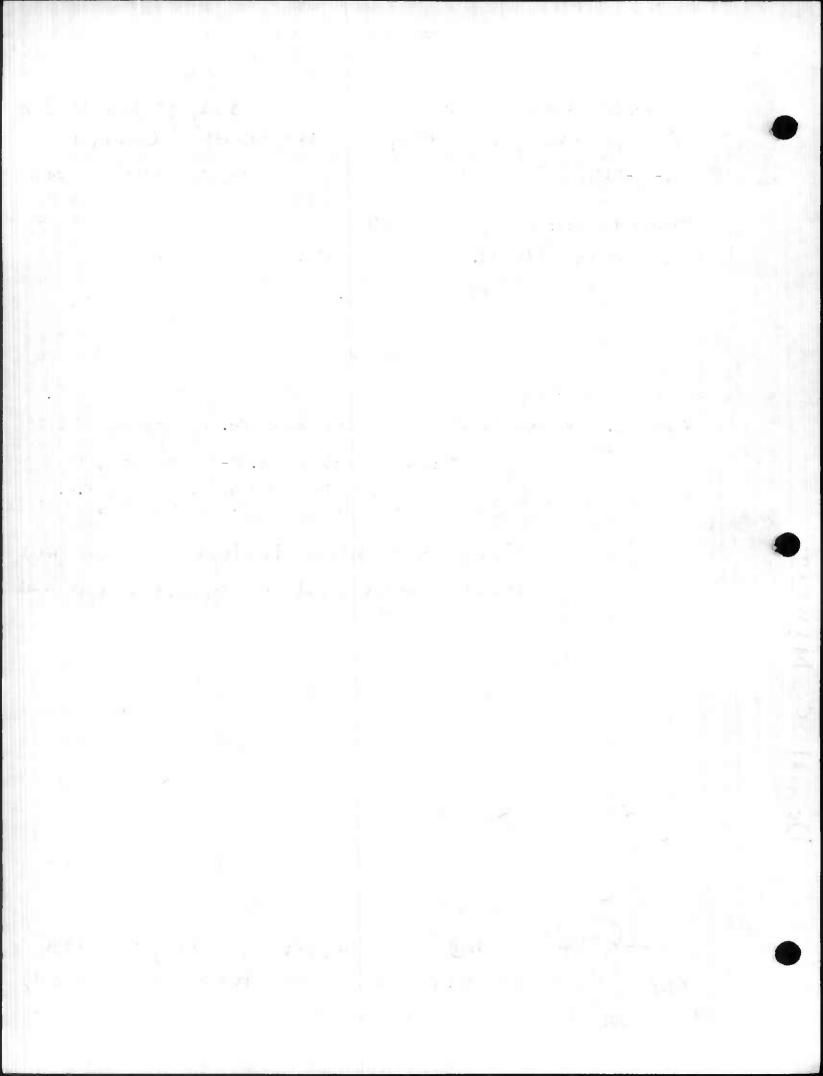
State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	He	g. No.				
Dhombian	1. Decedent's Name (First, Middle	a, Last)				2. Dete of Death Month	Dev	Year	3. Time of Death		
Physician /Medical	Marcella M. Nil	.an				July 11					
Examiner	4a Facility Name (If not institution	Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of									
	13318 Foxhall D	rive			Silver Sp or If Under 24 Hrs.	ring	Montg	omerv			
Funeral	5. Sociel Security Number		ge (In yrs. last bii	thday) If Under 1 Yes Months Day		8. Dete of Birth (Month, Day,	9		ce (State or Forei		
Director	215-58-8233	1□M 2夕F	7.7	Yrs.		July 2,1		Minne			
2	Usual Residence of Decedent		T			,					
nyla tho	10a. Stete 10b. County		10c. City, Tow	n or Location				10	d. Inside City Limi		
oto cto	Maryland Monts	gomery	Sil-	ver Spring					1 ☐ Yes 2∰ N		
vith the Ma or 28=4 • be notified Director	10e. Street and Number			10f. Zip Code		10	10g. Citizen of What Country?				
death with the Manyland rms 23s or 28s-f show Lmust be notified at neral Director	13318 Foxhall 1	Orive		2	0906		II	SA			
r Home 234 other must funeral	11. Meritel Stetus	12. Wes Decedent Armed Forces		13. Was Decedent of	Hispanic Origin? (Spiban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, et			
A P	1 ☐ Never Merried 2 ☑ Merri	ied 1 ☐ Yes 2€☐ If Yes, Give	No	1□Yes 2⊠N			Specify				
n 72 hours after death with the Manylan "natural", or items 23s or 28s-f show soldel Examiner must be notified at leted by Funeral Director	3 Widowed 4 Divorced	Year or Detes:					Opoony	Whit	te		
led within 72 hor lyglene. Nor than "natura 14, the Medical I	15. Decedent (Specify only highes	's Education It grade completed)	16a	Decedent's Usual Occ (Give kind of work don	e during most of work	ing 1	6b. Kind of Bu	isiness/Indu	istry		
within then the ken	Elementary/Secondary (0-12)	Cottege (1-4or	5+)	life. DO NOT use reti	red)						
e filed v other th vent, th		3	R	egistered N		Health	Care				
Be von	17. Father's Name (First, Middle, I	18. Mothers Nam	18. Mother's Name (First, Middle, Maiden Surneme)								
s 1 and 2 should be filed within the Health and Mental Hyglene. Item 27 is marked other than other traumatic event, the M To Be Comp	Edward Adams					indgren					
2 sho	19e. Informent's Name/Reletions	nip (Type, Print)	19b	. Meiting Address (Stre	et and Number or Rur	al Route Number,	City or Town,	State, Zip (Code)		
os 1 and of Heelth Item 27 other tr	John K. Nilan	(so		14 Sea Shao	low Colum			21046			
nt of He	20e. Method of Disposition 1 ☑ Buriei 2 ☐ Cremetion	3 □Removel from State	comoto	I Disposition (Name of ry, cremetory or other p	(ece)	Dete 2	Oc. Location -	City or Tow	m, Stete		
permit. Peges Department of I important: If Its any injury or or pace.	4 □ Donetion 5 □ Other (S)			f Heaven Ce	metery 17	/15/99 8	ilver	Sprin	g.Marvla		
Departi Import any in	21. Signeture of Funerei Service I	Licensee		22. Name end Add	ress of Facility				,		
80 = 8	Mark	12.61		Francis J.							
	23a. Pert1. Enter the disease, or shock, or heart feilure. List	complications that cause	d the deeth. Do	not enter the mode of d	rsity Blvc ying, such es cardiac	or respiretory arre	st,	1 /	Approximate		
Physician	SHOCK, OF Healt fellule. List	only one cause on eech	mie.						Interval Between Onset and Deeth		
/Medical	Immediate Cause (Final disease or condition a Metastatic Colon Cancer										
Examiner	resulting In death)										
<u> </u>			,-	consequence of):				1			
- E											
nd transit	Sequentially list conditions,	b	Due to (or as e	consequence of):				-			
e axecuted ian and urial-transit i Examin	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	b	Due to (or as e	consequence of):				1			
ata be axecuted yysician and ha burial-transit	Cause. Enter Underlying Cause (Disease or injury that initiated events	b		consequence of):				1			
rificate be assouted no physician and set the buriel-transit	Cause (Disease or injury	c						\$ 5 6 4 6 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6			
2 2 5	Cause. Enter Underlying Cause (Disease or injury that initiated events	c									
death certi	Cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as a	consequence of):	given in Part I.	23b. Did tol	Dacco use co	ntribute to	the cause of dea		
death certi	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last		Due to (or as a	consequence of):	given in Part I.						
death certi	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last		Due to (or as a	consequence of):	given in Part I.						
ss that the death certigned by the attending be detached for use by Physician/M	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last		Due to (or as a	consequence of):	given in Part I.	1 ☐ Ye	a 2 No	3 ☐ Probe	ebly 4☑ Unknown		
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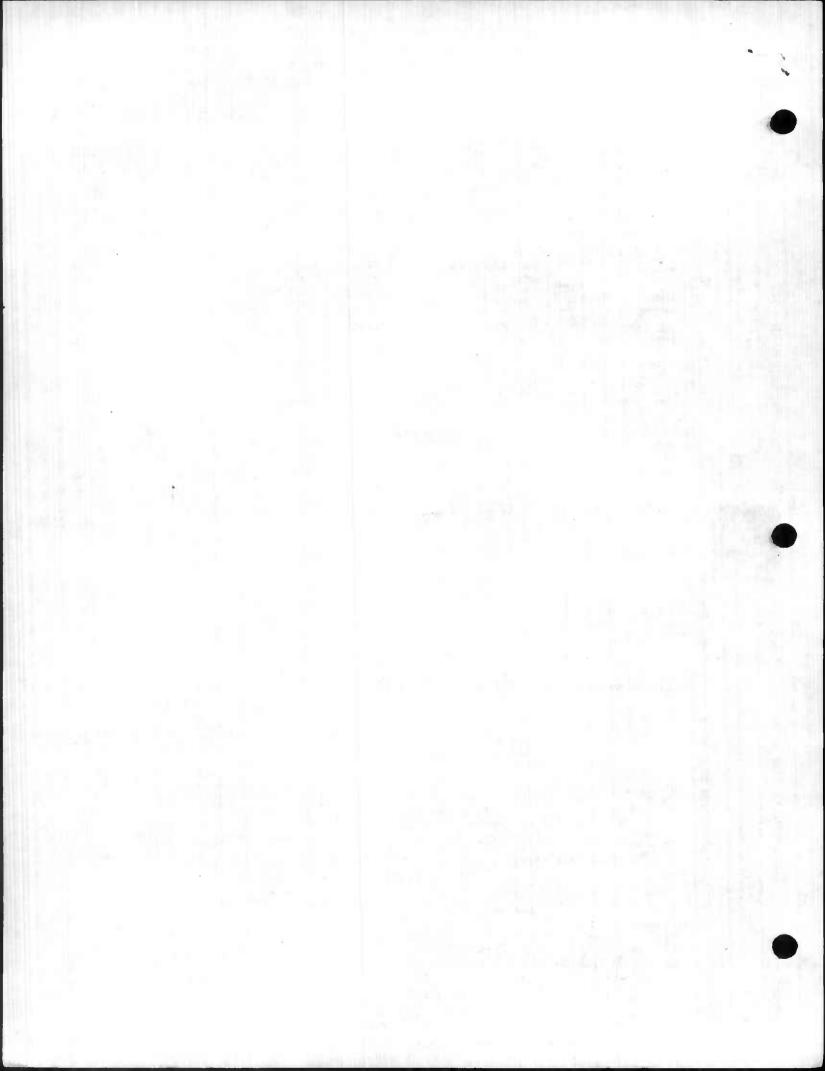
State of Maryland / Department of Health and Mental Hygiene

					,	Certificate o	f Death		Reg. No.		()		
	Discrete		1. Decedent's Name (First, Middle, La	st)				2. Dete of Dea	ath	3. Time of	Death		
	Physici /Medi		vaniel Charles Newcomer 3 44 9 1999 2, 39										
	Examir	ner	4e. Fectity Name (If not Institution, giv		مساد	460	4b. City, Town, or			4 1			
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	Funeral Director			Sex	6 (In yrs. lest bir	thde Months Day			1912P	9. Birthplece (State o Country) ENNSYLVA	r Foreign .Nia		
	/land		10a. State 10b. County		10c. City, Towr	or Location				10d. Inside Cit	ty Limits		
	Mar.	tor	Maryland Carro	el.l.	Sub	esville				1 ☐ Yes	2 17 No		
	or 28	Sire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	hat Country?			
	23a	rai	4015 London Br				21784		USA				
20	72 hours after death with the Maryland natural', or ftems 23a or 28af show yical Examinet must be notified at	by Funeral Director	11. Marital Stetus 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent B Armed Forces? 1 Yes 2/2/16 If Yes, Give		13. Was Decedent of the Yes, specify Control of the Yes 2000 N		Specify Yes or No- to Rican, etc.)	14. Rece Black Specify:	14. Rece - American Indian, Black, White, etc.			
5-0020	72 hours "natural",		15. Decadent's E	Year or Detes:	169	Decedant's Usual Occ	unation		16b. Kind of Bus	White			
215		Completed	(Specify only highest gra	ide completed)		(Give kind of work dor life. DO NOT use reti	ne during most of wo ired)	orking		mery War	.ds		
21	d 2 should be filed within in and Menial Hygiene. 7 is marked other than "raumatic event, me Men	EO	Elementary/Secondary (0-12)	Cottaga (1-4or 5		Painter			_	ment Sto			
pu	al Hy al Hy oth	Be	17. Fether's Neme (First, Middle, Last,				18. Mother's Na	me (First, Middle,	Maiden Sumeme)			
Maryland	should be find Mental I marked or umatic eve	10	Peter Troutu	vine			Sara	Lawren	ice				
Mar	2 shd and is me		19a. Informant's Name/Relationship (Mailing Address (Stre							
- 00	f Health Itam 27		Pearle I. Newco	omer Wif	e) 40	15; Londo Disposition (Neme of	n Bridge	Rd. St		Le, MD 2 Dity or Town, State	1784		
altimore	20 20 20		1 ☐ Burial 25 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemeter	y, cremetory or other p	rlece)						
Ħ			4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licar		Carro	ll Crema.		7-9	Hampst	ead, MV			
Ba	permit. Departmimportal any inju		100	00		Dritts	Funonal	Home ar	id Chap	el, P.A.			
			23a. Path. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do r	412 Was	hington	Rd. We	estmins	ter, MD	2115		
	Physician		shock, or heart failure. List only							Ought aug F	Deani		
9	/Medical		tmmediate Cause (Finet	Can	necti	re he	L F	1200		One	WEEK		
	Examiner		disease or condition rasulting in death)	a	Jun to for as a	ve hac	m1 10	wilmi		0.11	11/4		
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	ificate be executed g phy itician and as the burial-transit	Examiner	Sequentially list conditions,	b	Due to (or as a c	consequence of):		1.5	W4 0) 4				
60,	be ex cian a		Sequentially list conditions, if any, teading to Immediate Cause (Disease or Injury	C									
68760,	phy a	odic	that initiated events resulting in death) Last	ľ	Due to (or as a c	onsequence of):							
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0	by the	hys	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	i tha undarrying cause	given in Part t.			iribute to the cause of	Unknown		
ο,	res that iigned to be det	by P						''	148 20140	Sacriously 4	DIRTIOWI		
Records,	r requi	Completed I			24a. Was perfor	an autopsy med?	24b. Were autopsy fi evallable prior to completion of co of death?	0					
	The law ate hes page 2	Eo						1 D Y	es 200 No	1 ☐ Yes 2 🛣	Dio.		
Vitai		Bec	25. Was case raferred to medical				26. Place of De	ath (Check only o	ne)				
of V		To	exeminer?	Hospital: tnpatie	nt 2 ER/Ou	tpetient 3□ DOA	Other: 4 Nursing I	Home 5 ☐ Resid	lence 6 Other	r (Specify)			
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Sio	Attending or death. ector: After by the lune	cati	2 Accident Investigation				☐ Yas 2 ☐ No						
Division	h W %	Certification:	4 Homicide datemined	28e. Place of tnju building, etc	ry - At home, fai . <i>(Specify)</i>	rm, street, factory, offic	28f. Location (S City or Tow		r or Rural Routa Numi	ber,			
	pital ours eral (filled		29a. Cartifiar Contifying Ph	velcien: To the best o	f mu knawladaa	, daath occurred at the	time determed less	a and due to the a	(a) and man	nana a state d			
	To the Hospital or within 24 hours aff To the Funeral DI completely filled in	edicai	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and	yor investigation, in m	y opinion, daath occi	urred at the time, o	data and place, ar	ner sis stated. nd due to the cause(s))		
	within To th	Me	29b. Signature and titte of certifier)		29c. Lice	nse number			(Month, Dey, Year)			
) -X	- , n	20	D4	8006	3	Tuh o	its 190	19		
			30. Name and addrass of person who	complated cause of da	ath (Item 23a) (Type, Print)	1 h .						
			KOFI BOA	TEY,	200	Mamiri	al Hvi,	Wash	rinsper	, MI) 2	:1157		
	Sta	- 2.1	31. Date filed (Month, Dey, Year)		r's Signature	4 1							
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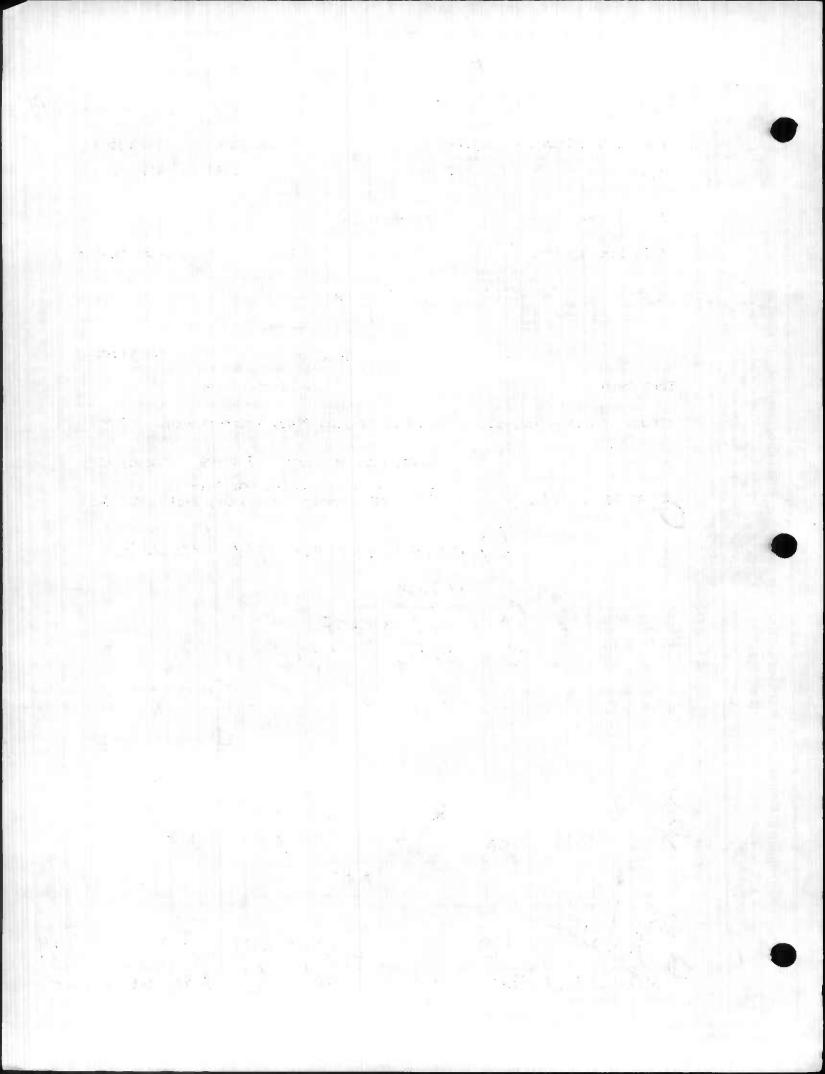


State of Maryland /	Dep	artmer	nt of	Health	and N	Mental	Hygiene
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יטטיק	G					- Total y la	Ce			Death			Reg. No.		13011
	Physician		1. Decedent's Name (First, Middle, Last)									2. Date of Death Month Day Yes		Year	3. Time of Death 1910 PM
	/Medical		ELEANOR DENISE OVERTON 48 Facility Name (If not institution, give street and number)							th Oh. To		JULY	5, 199		2320 211
-	Examiner		LANTIC HOS			iber)				BERL		cation of Deal		CESTER	0
	F		Security Number	6.5		7. Age (In vrs	. last birthday)	If Under	1 Year			8. Date of Bi			
	Funeral Director	213-	-88-0047	1	I□M 2\ F	3		Months	Days	Hours	Min.	APRIL	20,1962	WASH	place (State or Foreign ntry) HINGTON, D. (
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4	or 28e-f a be notified Director	10e. Str	eet and Number					10f. Zip	Code			T	10g. Citizen of	What Cour	ntry?
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1215-0020 within 72 hours after death with the Mendend	al', or iteme 23a or 28a-f aho Examiner mant be notified at by Funeral Director	11. Mari	ital Status Never Married 2		12. Was Dece Armed For 1 Yes If Yes, Give Year or De	ces? 2 No				Hispanic Ori an, Mexican Specify:		city Yes or N Rican, etc.)	9- 14. Rac Bla Specif	ck, White,	
21215-0020 d within 72 hours at	"netural",	-		edent's Ed		103.	16a, Dece	dent'a Usua	t Occu	pation			16b. Kind of B		
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and 2	d other	17. Fath	er's Name (First, Mic							18. Mother's Name (First, Midd					
aryia	marked other than imatic event, the M To Be Comp	R	OBERT SW	SWEARINGER						J0	AN	THOMP	CINS		
Z 2	476	19a. Inf	ormant's Name/Relat L DION OVE									Rural Route Number, City or Town, State, Zip Code) CLINTON, MARYLAND 20735			
altimore,	Department of Heal Important: If Item 2 eny Injury or other BROS.		thod of Disposition	inn 0 10	*D	20b. Place of Disposition (Name of cemetery, crematory or other) EDENTON, N.C.						Date	20c. Location	- City or To	own, State
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alt.	pourty by Injury	21. Sigr	nature of Funeral Ser	vice bicer	1588		2	2. Name and	d Addr	ess of Facili	y HII	NES-RIN	NALDI FU	NERAI	L HOME, INC
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	0 4		g in death) Last	L	d										
. 5	the attended for	Part II. C	Other significant con	ditions o	ontributing to dea	ath but not re	sulting in the u	nderlying ca	nuse gi	ven in Part I	l.	23b. Did	tobacco use co	ontribute to	o the cause of death
P.O.	20 5											10	Yes 2□ No	3 □ Pro	bably 4 SUnknow
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of Vita Physician:	this co	1)(5)	Yes 2□ No		Hospital: 1 ☐ In	patient X	EF/Outpatier		A		ursing Hor	ne 5□Res	idence 6 🗆 Oti	her (Specil	<i>'y)</i>
Vision of Attending Pi	ath. r: After ti e funera	10	ner of Death Natural 5 Pe Accident	nding restigation	28a. Date o	Injury Day Year)	28b. Time of Injury	1 M	Bc. Inju Wo 1 [ry at rk? Yes 2152			now injury occur		Mad
Division if or Attending	is ofter death. I Director: After ted in by the funeral Certification:			uld not be termined	206. Place						2	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
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To the	To the comple	29b. Sig	nature and title of se	rtifier)		29c.		se number	Ε.		29d. Date signe	1	
	20	30. Nam	e and address of per	son wine	completed cause				-	-144		Ma 3			
		24.5	/ XVV	WM,	XON			теет	, B	att1110	ore,	Maryla	nd 2120	T	
H	State Registrar	31. Date	filed (Nonfn, pay, Y	199	- /	gistrar'a Sign		Spa	est.						
CAMBRA	16 Day 605						-	11							



				State of	Marylanu	•	tificate of	Death		Reg. No.	2	35/8
Physicia: /Medica		1. Decedent's Name FRED	DIE	OH	EN3					Day - 12 - 1	Year 999	3. Tima of Death 8: 37 AM
Examine Funeral Director		4a Facility Name (#Washingt 5. Social Security No. 251-40-8	on Adver	ntist Ho	10.00	st birthday) Yrs.	If Under 1 Year Months Days		Park 8. Date of Bir	Mon	taom	ery lace (State or Foreign ntry)
2		Usual Residence ot			100 City	Town as Lo	-ation					Od Jackda City I Jaka
at, or items 23e or 28e-f show Examiner must be notified at	0	MD MD	Montgor	ma r v		Town or Lo	sburg				'	0d. Inside City Limits Yes 2 □ No
288-	Director	10e. Street and Num		mer j	Ge	al cher	10f. Zip Code			10g. Citizen of V	Vhat Cour	itry?
ad iii		18022 Si	inging P	ine				20886		United	Sta	tes
	by Funeral	11. Marital Status 1 □ Never Marrie 3 ☒ Widowed		Armed For	2 No		Vas Decedent of Yes, specify Cut	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Blace Specify	k, While,	ean indian, etc.
	Completed	(Speci	15. Decedent's E fy only highest gr			(Give	lent's Usual Occu kind of work done OO NOT use retire	during most of wo	orking	16b. Kind of Bu	usiness/îne	ustry
a d	5			4+			Tead	cher	4000 4 5 40 4 40		atio	n
0	9	17. Father's Name (t)					me (First, Middle	, Ma <i>iden Sum</i> am	10)	
	9	Dock Owens Lizzie Arter 19a. Intormant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta										(Code)
r traumatic e				Daughte	r			q Pine, G				
y or other t			_	Removal from S	tate	ca of Dispo netery, cren	sition (Name of natory or other pla eake Ceme	ace)	Date 7/14/99	20c. Location ·	City or To	own, State
any injury		21. Signature of Fur			CI							
once	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, NW, Wash., DC 20011										
sician edical miner		23a. art1. Enter the shock, or hear Immediate Cause (f disease or condition resulting in death)	t tallure. List only Final	nplications that cay one cause on ea	used the death. ch line.	Do not entr)	RATOR			5	Approximate Interval Between Onset and Death
nsit	niner	7766.00.00	_	b	An	b S a conseq						313
s the bur	/Medical Examiner	Sequentially list con if eny, leeding to im cause. Enter Under Cause (Disease or i that initiated events resulting In death) L	njury	c. Ca	Due to (or e	Ro	177	1	4		1	
hed for	Physicianym	Part tt. Other signific	cant conditions	contributing to dea	ath but not result	ing In the u	nderlying cause g	iven In Part t.	23b Did	tobacco use co	ntributa t	o the cause of death?
9	2									Yes 20 No		bably 4 Unknown
	Completed									an autopsy ormed?	av	ere autopsy findings valiable prior to empletion of cause death?
page 2	5								1 🗆	Yes 200No	1 [□Yes 20 No
90	9	25. Was case reterrexaminer?		Hospital:			_ 0	ther:	eath (Check only	_		,
E 8	0	1 ☐ Yes 2 0 1 27. Manner of Death	VO	28a. Date of	t Injury	R/Outpatien 8b. Time of	t 3□ DOA 28c. Inju	4 LI Nursing	Home 5 ☐ Resi 28d. Describe	denca 8 ⊟Oth how Injury occur		у)
e fune	31101	Natural 2 Accident	5 Pending investigation	(Month	n, Day Year)	Injury		ork? ☐ Yes 2 DNo		NA		
completely filled in by the funer	Certification:	3 Sulcide 4 Homicide	6 Could not be determined	288. Placa	of Injury - At hom g, etc. (Specify)	e, tarm, str	eet, tactory, office		28f. Location (City or To	Street and Numb wn, State)	per or Run	al Route Number,
tely fills	edical	29a. Certifier (Check only		miner: On the bas	sis of examinatio			time, date end plec opinion, death occ				
omple	Med	11	itle of certifies	and mann	er stated.		29c/Licen	nse number		29d Date signe	d (Month,	Day, Year)
Ö			W.	41))420	19 7	07-	12-	1899
	1	30 Name and addre	os/ot persen who	completed cause	of death (Item 2	(Type,	Print) TBZ	TO RES	九七	DB	020	7
State		31. Date tiled (Monti	h, Day, Year)	32. Re	egistrar's Signatu	6	4	1			e	V

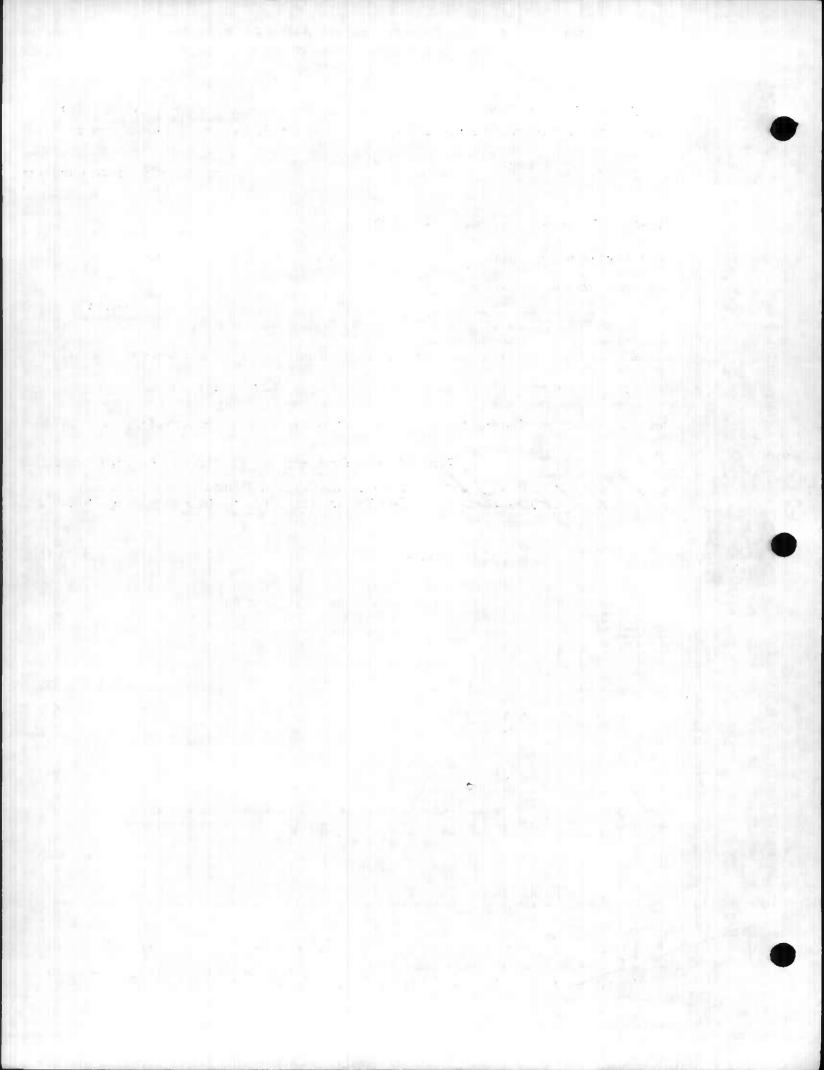


State of Maryland / Department of Health and Mental Hygiene

					Cei	rtificat	te of	Death		eg. No.		3351
Physicia /Medic		Decedent's Neme (First, Middle, STEPHEN MILLAF	D PARKER						2. Dete of Dee Month JULY	Dey 13,	Yeer 1999	3. Time of Deat
Examin	er	4a. Fecility Neme (If not Institution, I	give street end numbe	er)				4b. City, Town, or t		4c. County		
Funeral Director		5. Social Security Number 8 559-78-1941	. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs.	lest birthdey) 46 Yrs.	If Under Months				Montg Year) 1952	9. Birthp	r lece (State or Fore try) .fornia
tand two	1	Usual Residence of Decedent 10a. Stete 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Lim
uth with the Marylan 23a or 28a-f show ust be notified at	tor	Ca. Santa	Clara		Sunnyv	ale						1 ∑ Yas 2□
or 28	Director	10e. Street and Number				10f. Zlp	Code		1	0g. Citizen of V	What Coun	try?
ath w	raic	745 E. Benar	do				940			U.S.A.		
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decede Armed Force 1	s? XNo				Hispenic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Specify:		
2 hou	fed	15. Decedent's	Education		18e. Dece	dent's Usua	el Occu	pation during most of world)	62.2	16b. Kind of Bu		
21215-0020 d within 72 hours af giene. In them "natural", or the "matural", or the man and the giene.	Be Completed	(Specify only highest Elementery/Secondery (0-12)	College (1-4c	or 5+)						TI3 1 -		
A series	ဒီ	17. Fether's Neme (First, Middle, La	2		ETe	ctror	nics	Purchase	e (First, Middle,)	Elect:		S
Maryland d 2 should be file th and Mental Hy 7 Is marked othe traumatic event	To Be	Alvin	Parker					Adel		Hardy		
shoul Me mark		19a. Informant's Name/Relationship			19b. Mellir	ng Address	s (Stree			r, City or Town, State, Zip Code)		
and 2 alth a 27 is		Jeri M. Cobb (N	eice)		1802	Sonne	et C	rt. San J	Tose, Ca.	95131		
allimore, mit. Pages 1 ar partment of Hea portant: If item; y injury or othe		20a. Method of Disposition 1 MBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Piece of Disposition (Neme of cemetary, cremetory or other piece) Santa Clara Mission Cem., 7/16/99 Santa Clara										
Dealt. Departrimports any injuste.		21. Signeture Funeral Service Lic	hami	len				ess of Facility Ch				
		23a. Pert1. Enter the disease, or co shock, or heart feilure. List on	mplications that caus ly one cause on each	ed the deat								Approximete Intervel Between
Physician /Medical Examiner		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiratory arrest, shock, or heart feiture. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in deeth) e.								Onset and Deeth		
	ner				es a consecutive of the consecut		•				į	hours
nd	ami	Sequentially list conditions, Due to (or es e consequence of):									hours	
	90	8	if eny, leeding to immediate cause. Enter Underlying Cause. Due to (or as e consequence of): Due to (or as e consequence of):								hour	
that the death certed by the attending detached for use	Physician/	Pert ii. Other significant conditions	contributing to death	but not res	suiting in the u	nderlying o	cause gi	ven in Pert I.	23b. Did 10	obacco use cor	ntribute 10	the cause of dea
6 8 8 6	ρ	melano	ma						1 🗆 Y	es 210-110	3 Prot	pably 4 ☐ Unkn
been should	Completed								24a. Wes e perform	med?	co	are autopsy finding allable prior to mpletion of cause death?
VICIAN: The certificate rector, pag	ပိ	25. Was case referred to medical						00 Plans of Page	# Charlessters		+(Type 2000
yelclen: The lav s certificate has director, page 2	o Be	examiner?	Hospitel:	tlent 2 🗆	ER/Outpatler	nt 3□ DC	Ot Ot	han	th (Check only on		er /Snecifi	v)
Ing Ph Affer thi funeral	ation: T	27. Menner of Death 1 Neturei	28a. Dete of In (Month, I		28b. Time of Injury	-	28c. Inju		g Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred		,,	
To the Heaptal or Attending Privile 24 Hours later death within 24 hours after death. Completaly filled in by the funeral	edical Certification: To	3 Suicide 4 Homicide 8 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office bullding, etc. (Specify) 28f. Location (Street end No. City or Town, Stete)								n, Stete)		
the Hospi in 24 hou the Funer	edical	one) 2 Medical Ex	Physician: To the besaminer: On the basis end menner	of examine	owledge, deeth atlon end/or inv	vestigetion	, In my	opinion, deeth occu	rred et the time, d	ete and plece,	and due to	the cause(s)
5 ± ± € 5	×	29b. Signeture and title of certifier	Finhel	tei	MC	290	c. Licen	\$ 5453	2	9d. Dete signed	Month,	Day, Year)
		30. Name and address of person who Steven Finhe		-			VILI	E PIKE, I	BETHESDA	, MARYL	AND 2	20892
Stat	e	31. Dete filed (Month, Day, Year)	32. Regi	strat's Signe	eture	4	1/2	2. 1. 1				

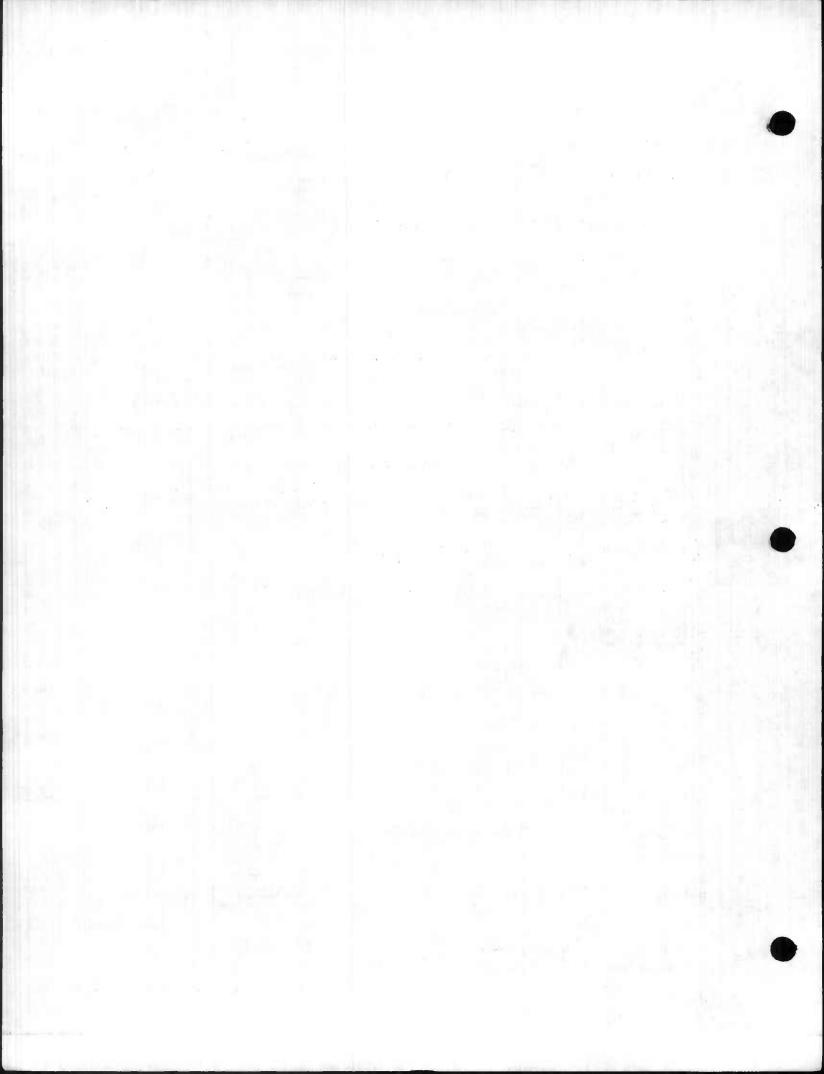
. . . . ----The arrivement will like the freezil with a series of make the plotters which was at

	Certificate of Death							Reg. No.		3. Time of Death
cian	Decedent's Nama (First, Midd	dia, Last)					2. Data of Dea Month	th Dey	Yeer	3. Time of Death
ical	Betty Sedberr						July	_	999	2:50 AM
iner	4a Facility Name (If not institute Shady Grove	on, give street end Advent	ist Hos	pital		4b. City, Town, or L Rockvil	le, MD	4c. County Mon	tgome	e ry
	5. Social Security Number	6. Sax	7. Age (In yrs.	last birthday)	If Under 1 Yaar		8. Dete of Birth (Month, Day		9. Birthple	ece (Steta or Forei
,	217-32-0175	1□M 20		Yrs.	Months Days	Hours Min.				n Carolin
	Usual Residence of Decedant		04				march 3	, 1/3/	MOLCI	Outottii
	10e. Stata 10b. Count	У	10c. City	y, Town or Lo	ocation		14 9	às .	10	d. fnside City Limit
jo	Maryland Monte	gomery		Damas	cus					1 ☐ Yes 2 ☒ N
Director	10e. Street and Number				10f. Zip Coda		1	0g. Citizen of V	Whet Count	ry?
	10441 Carlyn F	Ridge Roa	ad		208	372		USA		
Funeral	11. Maritai Status	12. Wes [Decedant Evar in U, d Forcas?	S. 13.	Was Decedent of I	lispanic Origin? (Span, Maxicen, Puerto	ecify Yes or No-		e - Amarice ck, Whita, a	
F	1 ☐ Never Married 2 Ma	rried 1 TY	as 2 No		1□ Yas 2⊠ No	Specify:		Specify		
d by	3 Widowed 4 Divorce		or Detes:						Whit	
ete	15. Deceda (Specify only high:	nt's Education ast grada complat	ed)	16a. Dece (Giva	dant's Usual Occup kind of work dona	pation during most of world)	king	16b. Kind of Bu	usinass/Ind	ustry
Completed	Elamantary/Secondary (0-12)	Colleg	ga (1-4or 5+)			a)				
	12 17. Fathar's Nama (First, Middle	l act)		Book	keeper	18. Mothar's Nam		Suburba Maiden Suman		ist
Be									, a,	
To		perry		10h Malli	nn Addanan (Chuna		a Mae Ur		State Zin	Code
	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Z James L. Prentiss (Husband) 10441 Carlyn Ridge Road Damascus, Marylar									1117
	James L. Prent 20a. Mathod of Disposition	iss (Hu			Carlyn I	Ridge Roa	d Damas	cus, Mar 20c. Location -		
	1 ☑ Burial 2 ☐ Cramation			amatary, crai	matory or other ple	ce)	0 4.14		0.1, 0	, 0.2
	4 Donation 5 Other (Specify) Fort Lincoln Cemetery 7/12/99 Brentwood, Marylan									ryland
	21. Signature unarel Service	1 1	de	177	T	0-111	Funerai	Home, I	nc.	
	Scott X	Im	ull	50	O Univers	sity Blvd	.W.Sil	ver Spr	ing.N	D 20901
	23a. P. rt1. Enter the diseas hock, or heart failure. Lis	or complications that only one cause	at caused tha daath on aach iina.	h. Do not and	tar tha moda of dyi	ng, such as cardiac	or raspiratory are	rast,	-	Approximata intervai Batween
		/)							Onset and Deeth
h	Immediata Causa (Finai disaasa or condition rasulting in death)	a	neumo	74 10.						2 2000
				70.00					i	2 day
1				or as a consac	quance of):					3 day
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xaminer		6	Dua to (o			Pl-sub.				s day
ai Examiner	Sequantially list conditions, if sny, laading to immediata cause. Enter Underlying Cause (Disease or injury	b	Dua to (o	or as a consac	quance of):	200				s day
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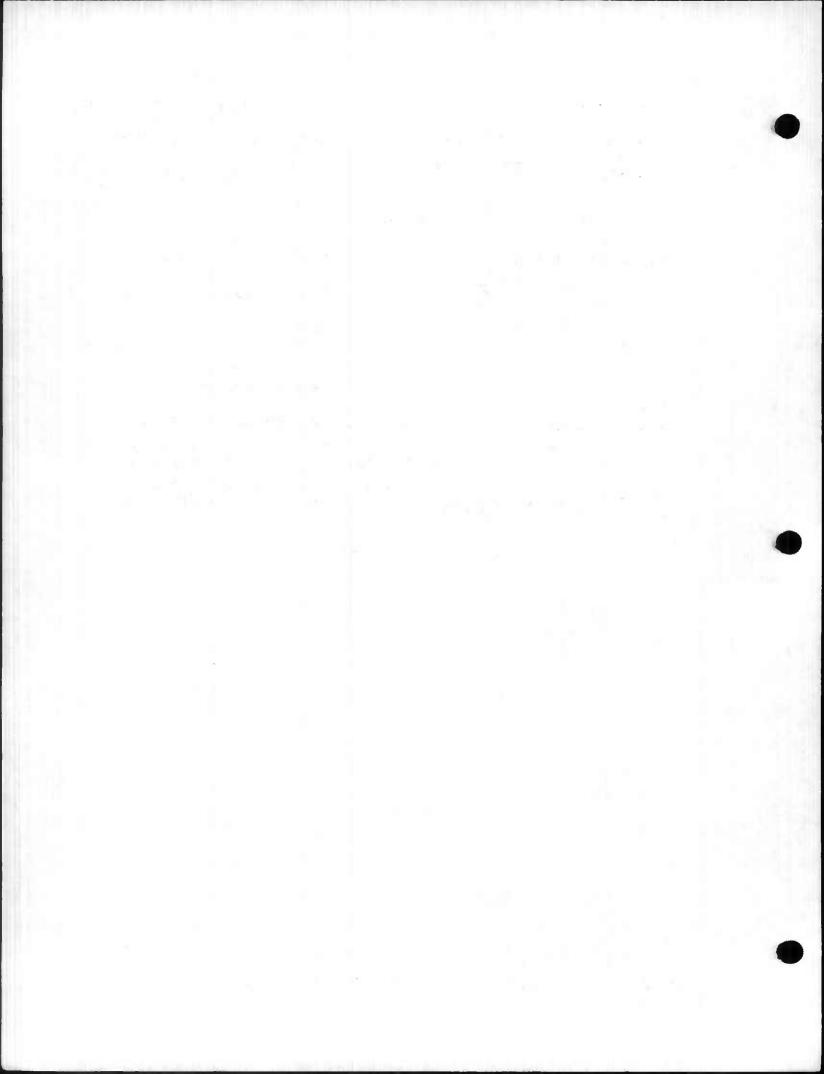
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Otate of Wie		ertificate of		nomainy	Reg. No.	. 23	102
п	Discrete to a	1. Decedent's Name (First, Middle,	Last)				2. Date of De Month		Yeer	3. Time of Death
	Physician /Medical	Madeleine Prev	ost-Sekuler				Ju1v		99	2:00 PM
3	Examiner	4a Facility Name (If not institution,				4b. City, Town, or L				2.00 11
6	Examine	1300 Canyon Roa	ad			C41 C-		26		
-	Funeral			e (In yrs. last birthd	(Ry) If Under 1 Year		8. Date of Bir (Month, De	Monte	9. Birthole	y ace (State or Foreign ry)
п	Director	214-70-2108	1□M 2및F	5.2 Yrs	Months Days	Hours Min.				
		Usual Residence of Decedent					DULY 3	1941	Franc	·e
	how	10a. State 10b. County		10c. City, Town or	Location				10	d. Inside City Limits
	72 hours effer death with the Maryland netural; or forms 23s or 28s-4 show file Esserine must be morified sted by Funeral Director	Maryland Mont	gomery	Si	lver Sprin	ø				1 ☐ Yes 2 ☑ No
	or 28ert a	10e. Street and Number			10f. Zip Code	-		10g. Citizen of W	hat Countr	y?
	23a C	1300 Canyon Road	1			20904		TICA		
	for death vices must	11. Marital Status	12. Was Decedent E	Ever in U,S. 1	3. Wes Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp	ecify Yes or No	USA 14. Rece	- America	
0	\$ 48 E	1 ☐ Never Married 2 € Merrie					HICAN, etc.)		, White, e	ic.
02	by Dy	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	_	1 ☐ Yes 2 ☑ No	Specify:		Specify:	Whit	te
0	ed within 72 hours ygiene. er then "natural", it, the Medical E., Completed by	15. Decedent		16a. De	cedent's Usual Occu	pation		16b. Kind of Business/Industry		ustry
2	within 7	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	100	ive kind of work done a. DO NOT use retire	during most or work d)	ang			
2	d withit		2		cetary/Rec	eptionist		Brokerag	e Fir	-m
Maryland 21215-0020	EIBE -	17. Father's Name (First, Middle, L.	est)					, Maiden Surname		
18		Marcel Prevos	st			Jeanne	Chene	211		
an		19a. Informant's Neme/Relationsh	ip (Type, Print)	19b. M	ailing Address (Street				State, Zip (Code)
Σ	こうれと	Stanley H. Sekul	er (husba	nd) 1300	Canyon R	oad Silv	er Snri	no Mary	1 and	2000/
6	of Heal	20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla		Date	20c. Location - 0	City or Tow	m, State
9	Pages nent of I rrt: If he iry or o	1 ☐ Burial 2 ☐ Cremetion : 4 ☐ Donation 5 ☐ Other (Spe					110100			
altimore,		21. Signature of Funeral Service L		Metropo	litan Crem 22. Name and Addre		/13/99	Alexandr	ia,V	irginia
B	Departi Departi Importu eny inju	NI Kai Stil	20	, F	rancis J.	Collins	Funeral	Home, In	ne.	
_	_	220 PM Salve the disease are		Man death Danie	00 Univer	sity Blvd	.,WSi	lver Spr	ing, M	D 20901 Approximate
	18.63	23a. P. 1. Enter the disease, or o shock, or heart feilure. List o	nly one cause on each lin	e.	-/ I de mode or dy	ng, such es cardiac	or respiratory a	rresi,		intervel Between Onset and Deeth
0	Physician /Medical	Immediate Cause (Finel	Kon	Diretry	tallere					511001 4110 50011
	Examiner	disease or condition resulting in death)								
ш		1000	S. J	to (or as a con	sequence of):	rgivendi	Ha De	1 1		
	cate be executed physician and a the burial-transit and callest Examiner		nvect	Ma	i					
_	icate be executed physician and a the burial-transit edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	- 1	Due to (or as a con	sequence of):					
68760,	burie B	Cause (Disease or injury	C						i	
87	di the	that initiated events resulting in death) Last	C.	Due to (or es e con:	sequence of):					
			d.						1	
Box	death certifi e attending od for use ad ician/Me								1	
o	et the death certi d by the attending eteched for use a Physician/M	Part II. Other significant condition	a contributing to death bu	t not resulting in th	e underlying cause gi	ven in Part I.	23b. Did	tobacco use conf	tributa to	the cause of death?
٥.	thet the deby detection y						10	Yas 2 No	3 Probe	ably 4 Unknown
o)	\$ 55 D									
Records,	The law requires that has been sign page 2 should be Completed by							an autopsy ormed?	avai	re autopsy findings ilable prior to
90	as b 2 st								of d	pletion of cause eath?
	of the co						10	Yes 211No	10	Yes 2□ No
Vital	yaicien: The lev is certificate has director, page 2 To Be Comp	25. Was case referred to medical				26. Place of Deel	th (Check only	one)		
	Physicien: this certifical director.	examiner? 1 Yes 2 No	Hospitel: 1 Inpatie	nt 2 ER/Outpa	tient 3 DOA	her: 4 Nursing Ho	ome 5 Pesi	dence 6 Othe	r (Specify))
10	g Phyrical dispersion of T. T.	27. Manner of Death	28a. Date of Injur (Month, Day	y Year) 28b. Time		y at	28d. Describe	how injury occurre	d	
9	Attending is death. sctor: After by the fune	1 Seriatural 5 Pending 2 Accident investiga		1.40.		Yes 2 No				
Division	tal or Attending P re efter death. al Director: Atter ti ed in by the funera Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			street, fectory, office		28f. Location (Street and Numbe	r or Aural	Route Number,
_	d bloom	70,110,110,100	bulloning, etc	. (Specify)			Only or 10	wn, Olaley		
	hour hour hy fills	29a. Certifier 1 5 Certifying	Physician: To the best o	f my knowledge, de	eath occurred at the ti	me, date and place,	and due to the	cause(s) and mar	ner as sta	ited.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	(Check only 2 Medical Es	camiger. On the basis of and menner ste	examinetion and/or	rimestigation, in my	opinion, death occur	red at the time,	date end piece, a	nd due to	ine cause(s)
	Withly Comp	29b. Signature end title of certifier	THE WAR		29c. Licens	se number		29d. Date signed	(Month, D	ay, Year)
	10) (///W	1001		1 16	0445		7/12/	99	
	()	30. Name and address of person w	no dompleted cause of de	eath (Item 23a) (Tw	pe. Print)					
			V			D 1 1-	7	1 .000	E0 0	202
m ^e	State	Joel L. Goozh, 31. Date filed (Month, Day, Year)	32. Registre	Kando Iph r's Signature	Road #105		ie, Mai	cy Land 208	132-2	493
	Registrar	.1111 1.4		nevar	4 loo	11				



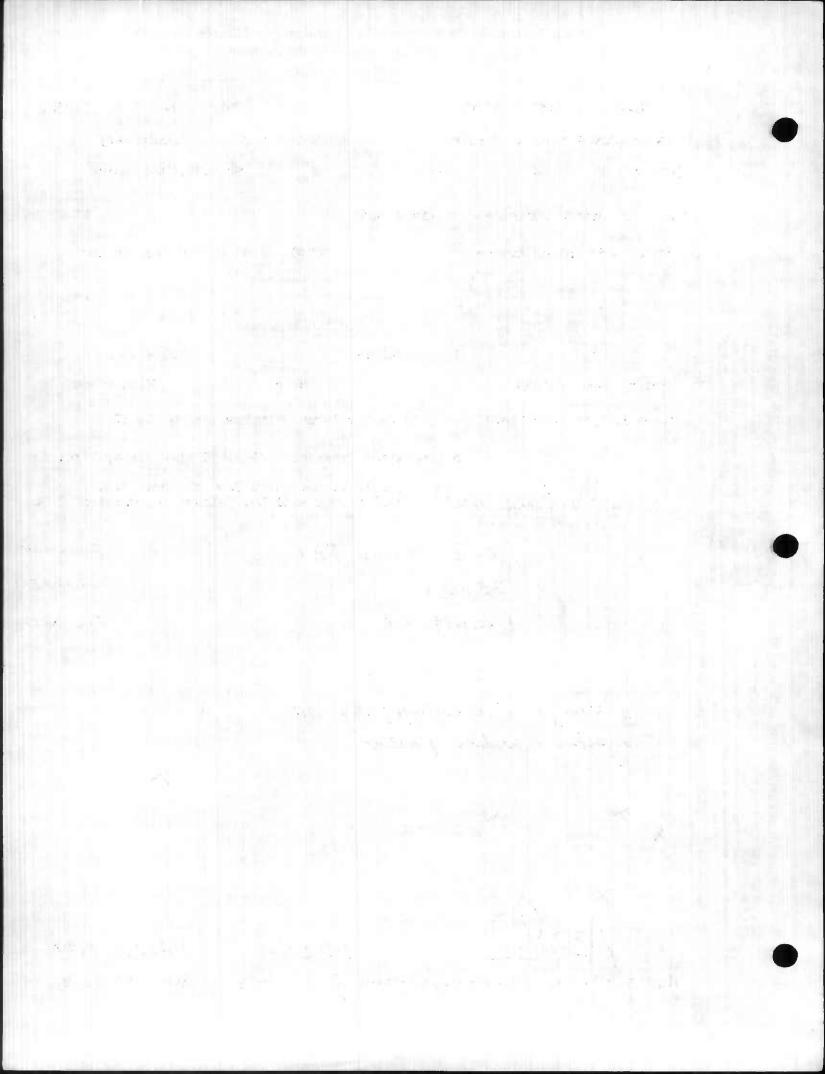
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	/Medic		INES ELSA P	ULISIC						JULY 1	4, ^{Day} 999	· dai	:35 M	
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	bue **		Usuel Rasidanca of Dacedant 10a. State 10b. County		10c. Ci	ty, Town	or Location					10d.	. Insida City Limits	
	Many	tor	MARYLAND MONTGOM	FRY		WHE	ATON						1 ☐ Yes 2 🕅 No	
	r 28a	Director	10e. Street and Number	DIC.		***************************************	10f. Zip Cod	ia		1	10g. Citizan ot	What Country	7	
	th wit		10862 BUCKNELL DR	TVE APT.	202		2	090	2		UNITED :	STATES		
020	72 hours efter death with the Maryland natural', or items 23a or 28a-f show of all Example I must be notified at	by Funeral	11. Maritel Status 1 Nevar Married 2 Married 3 Widowed 4 ADivorced	12. Wes Decede Armed Force 1 Tas 2 If Yas, Give Yeer or Date	ent Ever in U as? () No	J,S.	13. Was Dacedent It Yas, apecify 0		enic Origin? (Sp Maxican, Puarto Specify: ARGE			ca - American ck, White, atc y: HISPA		
5-0	72 ho natur	Completed	15. Decedent's E	ducation ada completed)		16a. D	ecedent's Usual Oc	cupatio	n na most of work	ina	16b. Kind of B	usinass/Indus	itry	
2	ithin 180.	nple	Elementary/Sacondary (0-12)	Collaga (1-4	or 5+)	'/	Giva kind of work do ife. DO NOT usa re		ng moot or work	9				
2	ife, Maryland 21213-0020 s 1 end 2 should be filed within 72 hours efter death with the Manylen Health end Mentel Hygiene. Iftee the marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examiner must be nothed at		12				SUPERVI	T				HOTEL		
and			17. Father's Name (First, Middle, Last,	,							, Maidan Suman	ne)		
2			ROSA GONZALEZ 19a. Informant's Name/Relationship (Tuna Print)		105 8	Mailing Addrass (Str		IXTA AL			State Zin Co	ada)	
<u>S</u>							5 FARRAGU						xaa)	
e,	Health Health tarm 27		WILLIAM PULISIC/S 20a. Method of Disposition	ON	20b. I		Disposition (Nama or cramatory or other		I. IIIAI	Deta	20c. Location		, Stete	
Baltimore,	permit. Pages 1 en Department of Heal Important: If Itam 2 any Injury or other ance.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		IIA		cramatory or other RIO JUNIN	piace)	7	24/99	BUENOS		,	
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	Physician /Medical		Immadiata Causa (Final	\/Tm			ELOM CANO	300						
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Division of	h. After fune	Certification:	27. Manner of Death 1 ☑ Naturel 5 ☐ Panding 2 ☐ Accident Invastigation	1	njury Day Year)	28b. Tin Inji		njury at Work? 1∐ Yas	2 🗆 No	28d. Dascribe	how Injury occur	red		
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	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edical	29a. Certifiar (Check only one)	yalcian: To the ba niner: On the besis end manner	s of examine	wiedga, o etion end/	death occurred at the or Investigation, in re	e tima, e ny opinie	deta end placa, on, deeth occurr	and dua to the red at the time,	causa(s) and modete and pieca,	annar as atate and due to th	e cause(s)	
	To the within 2 To the comple	Σ	29b. Signature end title of cartifiar	1 /			29c. Lic	ansa nu	umber		29d. Data algne	d (Month, De	y, Year)	
	12		Balko	Kerk			D09	834			JULY 15,	1999		
	-		30. Name end eddress of person who				ype, Print)							
			BARRY N. ROSENBAU				JT AVENUE	KEN	SINGTON	1, MD 2	0895-211	.0		
	Sta Registr		31. Data tiled (Month, Day, Year) JUL 16	1999 32. Regi	strat's Signa	atura	B. S.	rock	2					

DHMH 16 Rev 6/95



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	1. Decedent's Name (First, Middla, Last)		2. Data of Daath		3. Tima of Death			
Physician /Medical	Vivian Stanley Putnam		July		7:05P.			
Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Lo		4c. County o	Death			
	Washington Adventist Hospital	Takoma Pa		Montgo				
Funeral Director	5. Social Security Number 007-12-9605 6. Sex 7. Age (In yrs. last birthday) 1 Months World Rasidance of Decedent	Days Hours Min.	8. Data of Birth (Month, Day, Sept • 28	,1924	Birthplace (State or Foreign Cquintry) Maine			
4 show	10a. State 10b. County 10c. City, Town or Location Maryland Prince George's College Park				10d. Inside City Limits XX Yes 2 □ No			
r 28a-f ah Irector	10e. Street and Number 10f. Zip C	Coda	10	g. Citizen of Wi	hat Country?			
23a or ast be	8611 Rhode Island Avenue	20740		United	States			
air, or items 234 or 284-4 a Example must be notified Example must be notified by Funeral Director	1 Nevar Married 2 Married 1 Yes 2 No	nt of Hispanlc Origin? (Spy Cuban, Maxican, Puerto One of the Notice of	ecify Yas or No- Rican, etc.)		- American Indian, , Whita, atc. White			
tel Hygiene. d'other than "natural", avent, tre Medical En Be Completed by	Elementary/Secondary (0-12) Collega (1-4or 5+)	Occupation dona during most of work retired)	ing	6b. Kind of Bus				
other than vent, the la	12 1 Repairman 17. Fathar's Nama (First, Middla, Last)	18. Mother's Nem		Televis				
	Oscar John Putnam	Mabel	1 1 197		hardson			
r la marke traumatic TO	19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Run	al Routa Number,	City or Town, S	Stata, Zip Coda)			
P 00	Diane J. Dyer (daughter) 14 Easter	Avenue Wind	ham, Mai	ne 040	62			
= -	20a. Mathod of Disposition 20b. Place of Disposition (Nama cematary, cramatory or oth	a of ear place)	Data 2	Oc. Location - C	City or Town, State			
any injury or DDCs.	1 ☐ Burial ACCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Cr	ia, Virginia						
physician and supposes the burietransit and supposes and	23a. Part 1. Entar tha disaasa, or complications that ceused tha daath. Do not antar tha mode shock, or heart failura. List only ona cau seach lina. Immediata Cause (Final disaesa or condition rasulting in daath) Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Diseasa or Injury Cause (Diseasa or Injury	of dying, such as cerdiac	or raspiratory arra	st,	FOUR WEEK			
	Cause (Deads of Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of):							
the attending thed for use e	Part II. Other significant conditions contributing to death but not resulting in the underlying cer	use givan in Part i.	23b. Did tot	bacco uae conf	tribute to the cause of death?			
be detached for use by Physician/M	End Stage Cardinyopathy Congestive Cardiec Failure	witt!	1 Ye	s 2 No	3 ☐ Probably 4 ☐ Unknown			
2 should	Congestive Cardiec Failure		24a. Wes an perform		24b. Were autopsy findings available prior to completion of cause of death?			
page page			1 🗆 Ye	0 2X40	1 ☐ Yes 2 No			
Be Be	25. Was casa ratarred to medicel examiner?	THE WATER COMMENTS OF THE PARTY	h (Check only one	9)				
T L	investigation M	C. Injury at Work?	ome 5 Raside 28d. Describe ho					
	2 Accidant investigation 3 Suicide 6 Could not be detarmined 28a. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number of City or Town, Stata)							
Director: A Director: A d in by the f								
e Funeral Director: letely filled in by the	29a. Certifier (Check only one) 12 Certifying Physician. To the best of my knowledge, death occurred at 2 Medical Examinet: On the basis of examination and/or investigation, is and manner stated.							
Director: in by the	29a. Certifier (Check only one) 12 Certifying Physician, To me test of my knowledge, death occurred at 2 Medical Examination 2 on the basis of examination and/or investigation, is and manner stated.		red at the time, da	ate and place, a				
Winn 24 nous areo coart To the Funeral Director: Completely filled in by the Medical Certificat	29a. Certifier (Check only ane) 12 Certifying Physician To the best of my knowledge, death occurred at 2 Medical Examinar: 9n the basis of examination and/or investigation, is and manner stated. 29b. Signature and title/of certifier 29c.	n my opinion, death occur	red at the time, da	ete and place, a	nd due to the cause(s) (Month, Day, Year)			



State of Maryland / Department of Health and Mental Hygiene

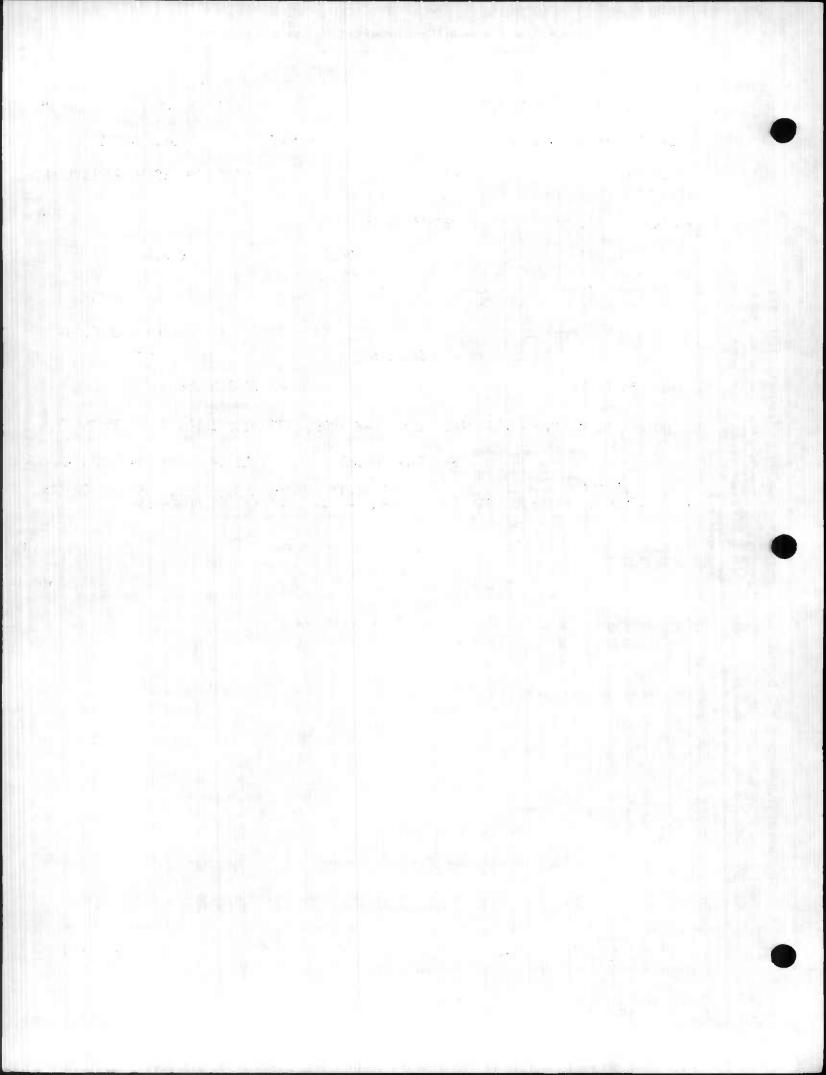
	Certificate of De	eath Reg. No.
Physician /Medica Examiner		2. Dete of Death Month Day Year 3. Time of Death Active, Town, or Location of Death Active, Town, or Location of Death Andallstown Baltimore
Funeral Director		Under 24 Hrs. lours Min. 8. Date of Birth (Month, Day, Year) June 2 1918 Md. 9. Birthplace (State or Foreign Country)
Maryland He ahow	10a. State Md Carroll 10c. City, Town or Location Sykesville	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Inter death with the Mai r frame 23s or 28s-1 a inter must be notified	10e. Street and Number 2214 Liberty Road 10f. Zip Code 21784	10g. Citizen of What Country? USA
	1 Never Merried 2 Merried 1 Yes 27 No	nlc Origin? (Specify Yes or No- lexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Specify: White
15.	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 6 16a. Decedent's Usuel Occupation (Give kind of work done during life. DO NOT use retired) College (1-4or 5+)	ng most of working 16b. Kind of Business/Industry health care
be file the dother work		Mother's Name (First, Middle, Maiden Sumeme) Mary Brown
		Number or Rural Route Number, City or Town, State, Zip Code) SykesVille, Md 21784
F P P P P	20a. Method of Disposition 1 Note: Surgicial 2 Cremation 3 Removel from Stete 4 Donetion 5 Other (Specify)	Date 20c. Location - City or Town, State 7-14-99 Sykesville, Md
Balt permit. Departri importa	21. Signature of Funeral Service Licensee 22. Name and Address of Pargu Haught Utruburt 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, so	Haight Funeral Home & Chapel 5 Sykesville, Md. 21784
Certificate be assected and indicate be assected and indicate by section and use as the burish ransit as the buris	Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): C. Systems Due to (or es a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or es a consequence of):	Lamape
S, P.O. DOX (see that the death certification by the attending be detached for use as the Physician Astronomy of the physician As	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	
Records, P.O. Dox le law requires that the death cent shas been signed by the attendings age 2 should be detached for use	Alute Resel failure	1 Yas 2 No 3 Probably 4 Unknown 24a. Wes en autopsy performed? 24b. Were autopsy findings evailable prior to
Re lav		completion of cause of death?
Of Vital Re Physician: The Lithis certificate haral director, page	axeminer?	Place of Death (Check only one)
ion of Vita nding Physician: ath. : After this certific e funeral director, effon: To Be	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work?	4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 2 No
Division o To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)
To the Hospital within 24 hours of To the Funeral I completely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and menner steted.	
To the common	29b. Signeture end title of certifier 29c. License nu H 42	97 4 This is A99
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2/133 N
State Registrar	31. Deterfiled (Month, Day, Year) 32. Registrer's Signeture JUL 1 2 1999 Server 4. Analy	!

				State of Ma	arylan			of Health		ental Hy	rgiene	9	23525
			1. Decedent's Name (First, Middle, Last)					0. 2 00		2. Date of D			3. Time of Death
Н	Physici		FLORENCE GRACE F	ICHARDSO	N					JULY 1	2, ^{Dey} 1999	Yeer	7:05 PM
	/Medi Examir		4e Fecility Neme (If not institution, give s					4b. City, T		ation of Dee		of Death	7.00 111
4	LAGIIII		ST. MARY'S NURSIN	G CENTER				LEONA	ARDTON	IN	ST. M	ARY'S	S
	Funeral Director		5. Sociel Security Number 6. Sex 578-40-7162	M 2 F 7. Age	e (In yrs. 1	last birthday) Yrs.	If Under 1 Months	Year If Under Days Hours	er 24 Hrs. Min.	8. Date of Bi (Month, D IARCH 2	rth ey, Year) 29, 1915	9. Birth	placa (State or Foreign ntry) NNSYLVANIA
	rylend		10a. Stete 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Series	8	MARYLAND ST. MARY	' S	MEC	HANICS							1 ☐ Yas 2/CYNo
	th with the Marylan 23s or 28s-f show	al Dir	29781 OAK ROAD				10f. Zip C				U.S.A.	What Cou	ntry?
020	Ind 21215-0020 be filed within 72 hours after des tal Hygiene. d other than "natural", or items avant, the Med cal Example in	by Funeral Directo	11. Meritel Stetus 1 Never Merried Married 3 Widowed 4 Divorced	2. Was Decedent I Armed Forces? 1 Yes 2 N N If Yes, Give Yeer or Detes:	Ever In U, No		Ves Deceder Yes, specification Yes 2	nt of Hispenic C y Cuban, Mexic No Specif		cify Yes or N tican, etc.)	14. Ra- Bla Specii	ck, White,	
1215-0		Completed by	15. Decedent's Educ (Specify only highest grade Elamentary/Secondary (0-12)	College (1-4or 5	i+)	(Give life. L		Occupation done during mo retired)	ost of workin	9	16b. Kind of B MARYLAN EDU		ARD OF
		Be	12 17. Father's Neme (First, Middle, Last) DAVID W. CLOSE	2		SECRE	TAKT			(First, Middle	, Meiden Sumer		
ary	should nd Men marks	2	19a. Informent's Name/Ralationship (Typ	oe, Print)		19b. Mallin	g Addrass (1			per, City or Town	, Stete, Zij	o Code)
Baltimore, Ma	EZNE		LAWRENCE E. RICHAR 20a. Method of Disposition		20b. P	29781 lece of Dispo	sition (Nema	of	ECHANI	CSVILI Dete	E, MARY		
m	Pag ment ant: H												RF, MARYLAND
Ball	Depart Import any in	J	21. Signeture of Euperal Seorce Vicensee K JUHN P. KNISLEY M01164 22. Name end Address of Fecility THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Interval Between Interval Between										
			23a. Part1. Enter the diseese, or complice shock, or heart failure. List only on	etions thet caused e cause on each lin	the deeth	n. Do not ente	er the mode	of dying, such a	as cerdiec or	respiretory	arrest,	1	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in death) e	End	S	tage	2	CHIT	_				
		liner	hadaning in dealing	End	Oue to (o	stag	uance of):	CA	D			1	few month
x 68760,	satificate be executed Jing physician and se as the bunei-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	Re	no	r as e consed r as e conseq	fa	lure	_			~	1 mont
. Box	deeth certific e attending p ed for use as	Physician/Med	Part II. Other significant conditions con-	ributing to death be	ut not resi	uiting In the ur	ndertving cau	ise given in Par	rt I	23b. Dlo	tobacco use co	ontribute 1	to the cause of death?
s, P.O	requires that the de seen signed by the a hould be detached t	by Phys									Yss 2□ No		
of Vital Records,	2 S S	Completed								24a. Wa per	s an eutopsy ormed?	91	Vere autopsy findings vailable prior to ompletion of cause death?
20	The ate h	Co								1 🗆	Yes 2 No	1	☐ Yes 2☐ No
Vita	iclan: The certificate rector, pag	Be	25. Was cese referred to medical examiner?	nenital:						(Check only			
	를 로 등	tion: To	27. Manner of Deeth 1 Neturel 5 Pending	28a. Date of Inju (Month, De	ry	ER/Outpetien 28b. Time of Injury		Other: 4 20 c. Injury et Work? 1 \sum Yes 2[2		how Injury occu		ify)
Division	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide Investigation Could not be determined 28a. Place of Injury - At home, farm, street, factorial building, etc. (Specify)								(Street and Num own, State)	ber or Rui	ral Route Number,
	To the Hospital within 24 hours. To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 Certifying Phys		examinet								
	Within To the comp	X	29b. Signature and title of certifier	~ / /			29c. l	License numbe			29d. Date sign	ed (Month	, Day, Year)
) A)SW	an			I	> 41	066		(-	13-	99
			30. Nema and address of person who con	nplated causa of d	aath (Itam	23a) (Type,	Print)					-A	15.

State Registrar A. D. Shah, P. O. Box 664, Leonardtown, MD 20650

1. Date filed (Month, Dex, Year)
1999

32. Registrer's Signature



	State of Maryland / Department of Health a Certificate of Death		Reg. No.	60950						
Di	1. Decedent's Name (First, Middle, Last)	2. Date of Dec Month	Day Year	3. Time of Death						
Physician /Medical	CHARLES L. REINSTEIN	JÜLY 1	1, 1999	9:25 AM						
Examiner		m, or Location of Death	4 20 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
	HEBREW HOME OF GREATER WASHINGTON ROCKV		MONTGOMER							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 145.16.2999 75 Yrs. Hours 145.16.2999	Min. 8. Date of Birt (Month, Da) 1.23.1	y, Year) 9. Birth 924	nplace (Stete or Foreig untry) NY						
D	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits						
Marylan f ahow	MD MONTEGONTEDM POGRATELLE		0.00	1 X Yes 2 □ No						
death with the Maryland ms 23s or 28s-f show Livest be notified at	MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 6105 MONTROSE ROAD 20852		10g. Citizen of Whet Country? USA							
ne 23e	11. Marital Stetus 12. Was Decedent Ever in U.S. 13. Wes Decedent of Hispanic Original Control O	In? (Specify Yes or No-	pecify Yes or No- 14. Rece - American							
or he	11. Marital Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Merried 2 □ Married 1 □ Yes, specify Cuban, Mexican, 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify:	Puerto Rican, etc.)		i, etc. ITE						
et et	15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	18b. Kind of Business/	ndustry						
y within jiene.	Elementery/Secondery (0-12) College (1-4or 5+) POLICE SGT.		LAW ENFORCE	MENT						
al Hyger and a series of the s		's Name (First, Middle,								
Menta Menta Menta Menta To E	HARRY REINSTEIN EST	ESTHER PITTLE								
and h	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,									
and assith n 27	PHYLLIS OSOFSKY/DAUGHTER 6421 SHANNON CT., C	LARKSVILLE	, MD 21029							
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avant, the Medica. To Be Compl	20e. Method of Disposition 1	Date IS 17.13.99	OLNEY, MAR							
ortar Inju	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility	1		de auto. de ver						
Depa Important In Poce	Sonald C. Stattlenger 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852									
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e.									
te be axecuted ysician and ne burial-transit Ical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):									
	resulting in death) Last Due to (or es e consequenca of): d.									
deatr d for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did	tobacco use contribute	to the cause of death						
requires that the death certifical person signed by the attending plantould be detached for use as to should be detached for use as the by Physician/Mec	DIABETES	10	Yes 20 No 3□Pr	obably 4 Unknow						
The law requires pate has been signate has been signage 2 should be Completed b		24e. Was perlo		Were autopsy findings ivailable prior to completion of cause of death?						
The la		101	Yes 2006	☐Yes 2☐ No						
Physician: The lights certificate har this certificate har all director, page: To Be Com	25. Was case referred to medical 26. Place	of Death (Check only o								
hysici nis cer il direc	examiner? 1 Yes 2 No	rsing Home 5 Resid	denca 6 □Other (Spec	cify)						
Attending Physician: r death. sctor: After this carific by the funeral director, lification: To Be (27. Menner of Deeth 1 Natural 5 Pending (Month, Dey Yeer) 28a. Date of Injury (Month, Dey Yeer) 28b. Time of Injury Work? 1 Natural 5 Pending (Month, Dey Yeer) 38b. Time of Injury Work? 1 Yes 2 N		how injury occurred							
tal or Attending P rs after death. al Director: After t ied in by the funers Certification:	3 Sulcide 4 Homlcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, tectory, office City or Town, Stete)									
To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end concept and manner stated.	d place, and due to the h occurred at the time,	cause(s) and manner as date and place, end due	stated. to the cause(s)						
	29b. Signature and title of certifier 29c. License number 0249	1 / 6	29d. Dete signed (Month)							
6	30. Name engladdress of person who coppleted cause of death (Item 23e) (Type, Print)	TKE Rd 1	PACKLINI.	- MD						

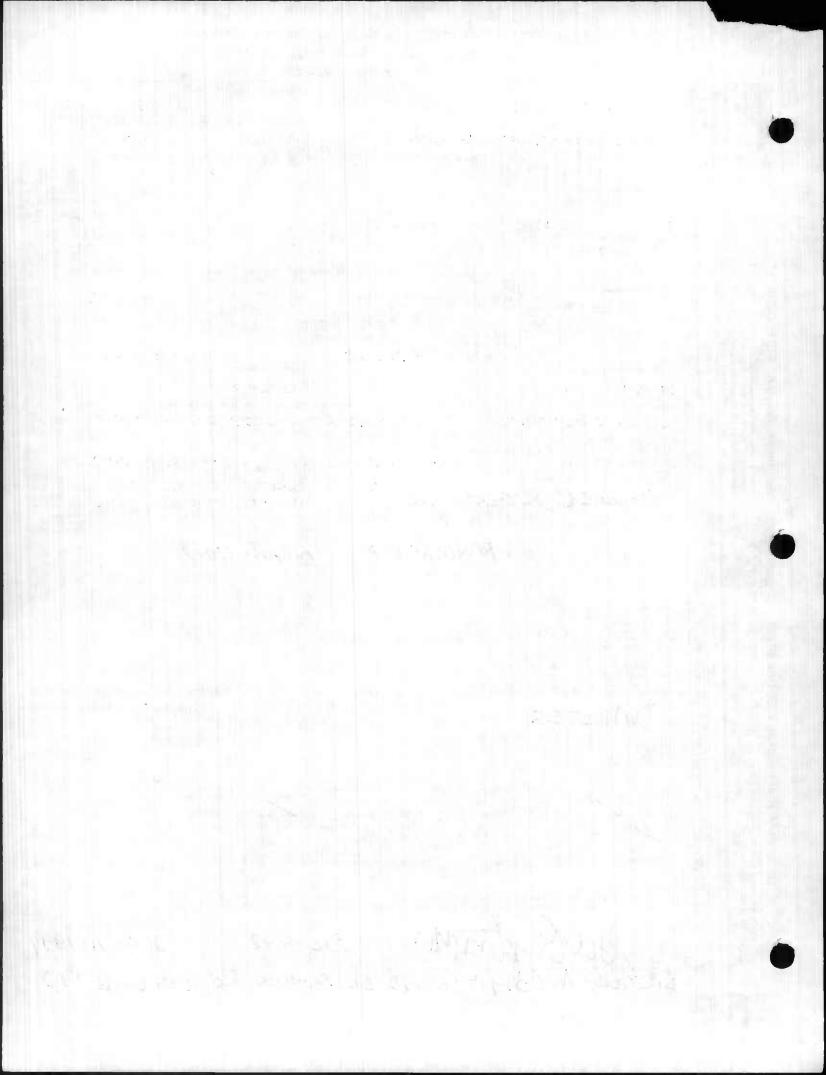
State Registrar 31. Dete filed (Month, Day, Year)

32. Registrar's Signature

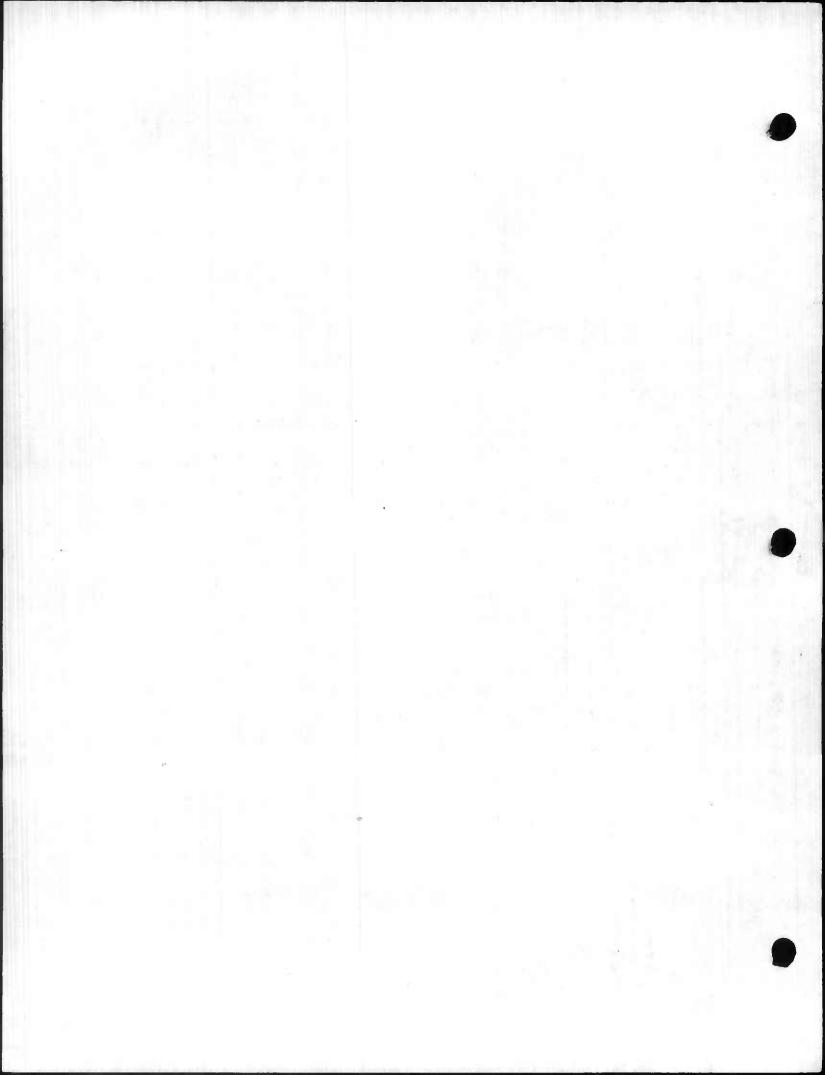
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Baltimore, Maryland 21215-0020

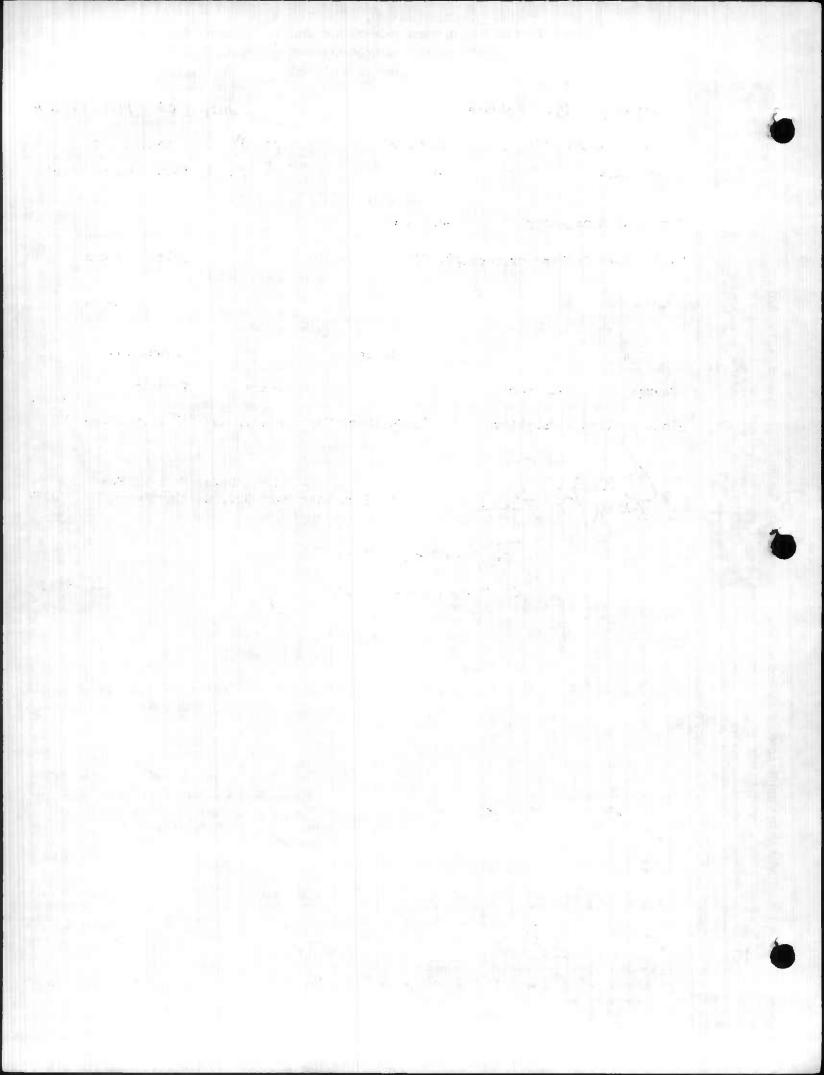
Division of Vital Records, P.O. Box 68760,



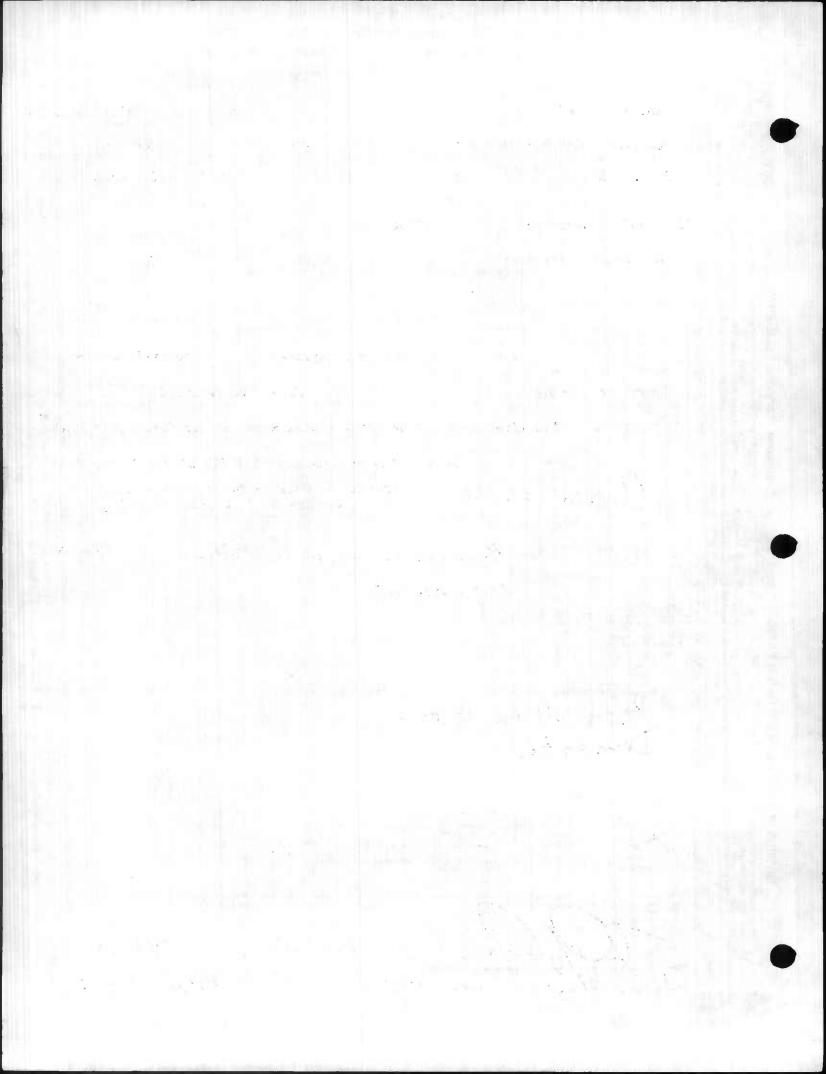
	•	epartment of Health and Men Sertificate of Death	Reg. No.	60001					
Physician /Medical	1. Decedent's Neme (First, Middle, Last) Helen Ro		Date of Death Month Day Year C1 1979	3. Time of Death 720P/7					
Examiner Funeral Director	4a Facility Nama (If not institution, give street and number) HUMAVA 5. Social Security Number 234-36-6949 6. Sex 1 M 2 DE 72	4b. City, Town, or Location (C) Co Co Co Co (Ey) If Under 1 Yeer If Under 24 Hrs. 8. [6] Months Days Hours Min. 0.00	HOWAI	thplace (State or Foreign punitry)					
land was	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits					
death with the Maryland me 23e or 28e-f show create be notified at ner at Director	Maryland Baltimore	2		1 Yes 2 No					
vith the Ma or 28e-f s be notified	10a. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?					
th wil	303 South Bentlow Street	21230	United St	ates					
urs after alt, or its currents by Fui	3 Widowed 4 Divorced Year or Dates:	13. Wes Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical 1 ☐ Yes 2 No Specify:	n, etc.) Black, Whit						
72	15. Decedent's Education 16a. D. (Specify only highest grade completed)	ecedent's Usuel Occupation live kind of work done during most of working le. DO NOT use retired)	16b. Kind of Business	/Industry					
s 1 and 2 should be filed within them 27 is marked other than other traumatic event, the it	Elementary/Secondary (0-12) College (1-4or 5+)	ensed Practical Nurse	Nursina						
be filed d other vent,	17. Father's Neme (First, Middle, Last)		st, Middle, Maiden Sumeme)						
Mental Mental or	Frank Lazan	Anna V	arga						
d 2 should be file th and Mental Hy 7 is merked oth traumatic event		lailing Address (Street end Number or Rural Ro		Zip Code)					
other tri		10 Queens Park Road	T	21122					
Pages 1 ent of H nt. if Ne ry or od	1 2 Burlal 2 Cremation 3 Removel from State cemetery.	isposition (Name of cremetory or other place) IR Grove Cemetery 7/14	20c. Location - City or						
permit. Pages 1 a Department of Hee Important: if item any injury or othe	. Signatur unera Service Licensee	22. Name and Address of Facility ROBERT J. MURPHY FUND	ERAL HOME, INC.	, west vinal					
Physician	23a, Pert1. Enter the disease, or complications that ceused he meth. Do not shock, or hear failure. List only one cause or could line.	4510 WTLSON BLUD, ARI enter the mode of dying, such as cardiac or res	piratory arrest,	Approximate Intarval Between Onset and Death					
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cata be executed physician and the burial-transit	Sequentially list conditions, If any, feading to immediate cause. Enter Underlying Cause (Disease or Injury c.	sequence of):							
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aw requires to been so 2 should pieted	Ventilator de genden	+	performed?	Were autopsy findings available prior to completion of cause of death?					
yelclen: The law is certificate has t director, page 2 s fo Be Compi			1□Yes 2No	1 ☐ Yes 2 ☐ No					
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ng Physician: fier this cartific uneral director, on: To Be	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Output	e of 28c. Injury at 28d. Work?	5 Residence 6 Other (Spe Describe how Injury occurred	ecity)					
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To the Hospital within 24 hours To the Funeral completaly lilled									
To the comp		29c. License number	29d. Date signed (Mont	th, Day, Year)					
_5	30. Name and address, of person who completed cause of death (Item 23a) (Ty	DY1617	Jul 12	1559					
	Gary Karlow Mr 10805 /fich	16 us Ridge Rel Cola	unbia Mol Z	1044					
State Registrar	31. Date-filed (Month, Day, Year) JUL 14 1999	B. Sports							



	Decedent's Neme (First, Middle, La	et)		ertificate of	Dealli	2. Dete of De	Reg. No.		3. Time of Deat				
ician dical	MARY B.	Robison				Month July	Dey 08	Year 1999	044Z X				
niner	4a Fecility Neme (If not institution, giv				4b. City, Town, or L		4c. Count	y of Death					
	Shady Grove A	Adventist	Hospit	al	Rockvil	le MD		gome					
al	5. Sociel Security Number 6. S	Sex 7. Age ('In yrs. lest birthde	y) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bird (Month, De Feb 2,	h y. Year)	9. Birthpl Count	lece (State or For try) Sylvania				
or	202-44-9040	IOM 20F	91 Yrs.			Feb 2,	1908	Penns	sylvania				
	Usuel Residence of Decedent 10a. Stete 10b. County	1	Oc. City, Town or	Location				10	Od. inside City Lir				
5									1 □ Yes 2 😿				
Director	Maryland Montgome	ery	Germant	10f. Zip Code			10g. Citizen of	What Count					
Ö		- 1	. II.ali		7./		United States						
era	20406 Shore Harbon	12. Wes Decedent Ev		208. 3. Wes Decedent of F		pecify Yes or No							
Funeral	1 ☐ Never Merried 2 ☐ Merried	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cub	an, Mexicen, Puerto	Ricen, etc.)	Bleck, White, etc.						
by	3 ₩idowed 4 Divorced	If Yes, Give A Year or Detes:		1 ☐ Yes 2 ₹ No	Specify:		Specify: white						
3	15. Decedent's Ed	ducetion	16e. Dec	cedent's Usuel Occup	petion	16b. Kind of I	16b. Kind of Business/Industry						
Completed	(Specify only highest gra Elementery/Secondary (0-12)	College (1-4or 5+)	life	ve kind of work done . DO NOT use retire	dunng most of won d)	king							
EO	4	College (1 401 51)		Teacher			Education						
Be	17. Fether's Neme (First, Middle, Last,)			18. Mother's Nem	e (First, Middle.	Maiden Suma	me)					
To E	George Brau	tigam			Elvir	a	Trembl	У					
once. To Be Completed by Funeral Director	19a. Informent's Neme/Reletionship (Type, Print)		ailing Address (Street									
	Elsie Robison, Da	aughter	2040	6 Shore H	arbour Dr	., Apt	"G" Ger	mantov	wn, MD				
	20e. Method of Disposition 1 Buriel 2 Cremetlon 3 C	3Damarral from Ctata	20b. Place of Dis	sposition (Neme of rematory or other ple	ce)	Dete July 12	20c. Location	- City or To	wn, State				
	4 Donation 5 Other (Special		Independ	dence Ceme		1999	Avel1a	a, Pen	nsylvan				
3	21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home												
8	March	4		10 East D	eer Park								
	23a. Pert). Enter the illeese, or com shock, or heert all re. List only	plications thet ceused th							Approximate Interval Betwee				
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by Physician/Medical	Ceuse (Disease or injury thet initieted events resulting in death) Last	d	not resulting in the	a underlying ceuse gi	ven in Pert I.	10	Yss 2 No	3 □ Prot	pably 4□Uni				
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by Physician/Medical	Ceuse (Disease or injury thet initieted events resulting in death) Last	d	not resulting in the	e underlying ceuse gi	ven in Pert I.	1 🗆	Yss 2 No an autopsy	3 Prot	pably 4 Unit				
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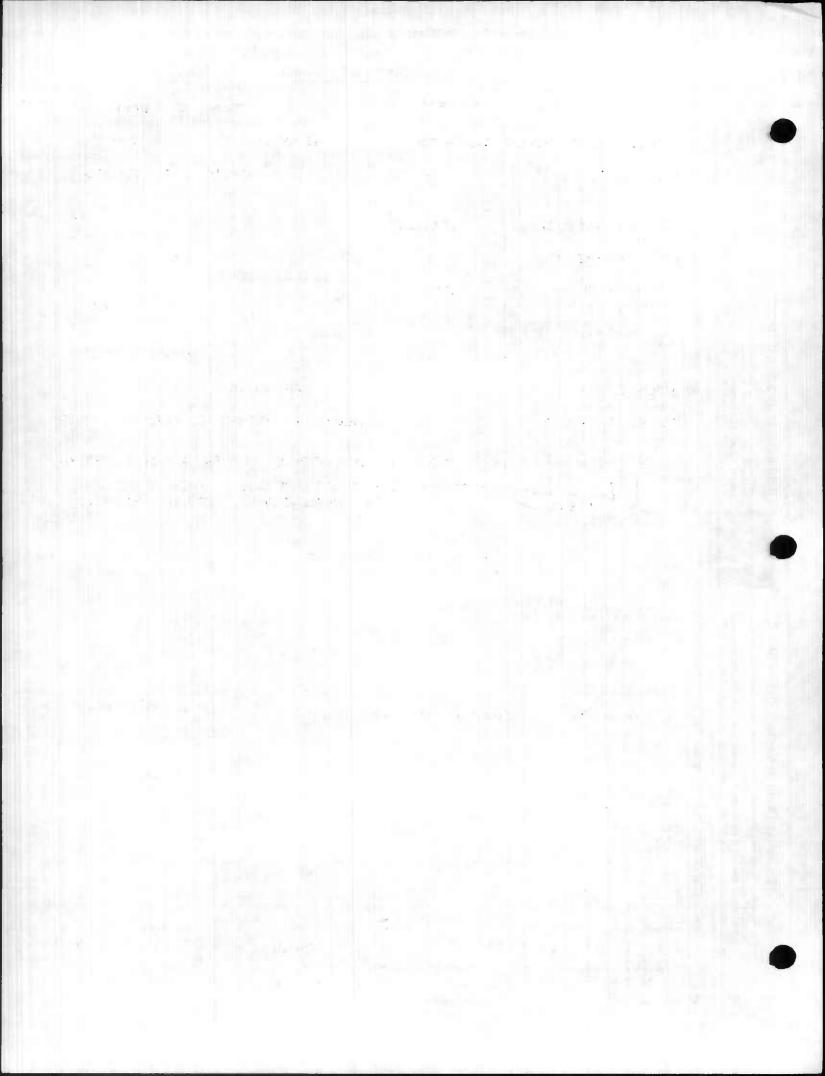


			State of Maryland / Department of Health and N	-	Reg. No.		5529		
			1. Decedent's Neme (First, Middle, Last)	2. Dete of De Month		Year 3	. Time of Deeth		
	Physici /Medi		Vincent S. Roddy	July		1999	3:55 PM		
	Exami		4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Lo	ocation of Deat	h 4c. County of	of Deeth			
			Montgomery General Hospital Olney		Mont	tgomer	77		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Yeer If Under 24 Hrs. Months Devs Hours Min.	8. Dete of Bir (Month, De	th ev. Year)	9. Birthplece	(Stete or Foreign		
п	Director		578-32-7366 91 Yrs.		3, 1907	Ohio			
	p .		Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location			104	Inside City Limits		
	show show	-	Too. County			100.	1 Yas 22 No		
	Ne M	Director	Maryland Montgomery Silver Spring						
	72 hours effer death with the Marylend natural', or flems 23a or 28s-f show little Exeminer must be notified at	Dir.	10e. Street and Number 10f. Zlp Code		10g. Citizen of W	net Country's	,		
	ath v	rai	1704 Chester Mill Road 20906		USA				
	er de	Funeral	11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Sp If Yes, specify Cuben, Mexicen, Puerlo	ecify Yes or No Rican, etc.)		- American c, White, etc.			
20	or i	by F	1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:		Specify:				
8	72 hours "natural",	d b	3 ☑ Widowed 4 □ Divorced Yeer or Detes:		401-14-19	Whi	- Warry Control of the Control of th		
5	nat nat	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Bus	siness/indus	try		
12	within ene.	Ę	Elementery/Secondery (0-12) College (1-4or 5+)						
מ	DO		5 + Electrical Engineer 17. Fether'a Neme (First, Middle, Last) 18. Mother's Neme	e (First, Middle	Federal		nment		
an	A de p	o Be							
2	should b ind Menta inarked umatic av	F	Cornelius Roddy 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rur	Butteri		State Zin Co	ode)		
Maryland 21215-0020	d 2 s th ar 7 is trau						20906		
0	- P E E		Florence R. DiMisa (daughter) 1704 Chester Mill Road 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location -	Z, Mary City or Town	Land State		
0	00								
Baltimore,		1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)							
Ba	permit. Peg Department Important: if any Injury o		21. Signetur of Funerel Fervice Licens 22. Name end Address of Fecility Francis J. Collins	L Home, I	Inc.				
_			23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec shock, or heart feliure. List only one leuse on each line.	.,W.,S:	llver Spr	ing,M	D 20901		
в			23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec shock, or heart feiture. List only one deuse on each line.	or respiretory e	errest,	Ini	pproximate tervel Between nset and Deeth		
1	Physician					ا و	A Deetil		
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) e. Hypoxemic Daysinche, i	ailu	9	10	acys		
		1	Due to (or es a consequence of)						
	ted nsit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying							
6	and and al-tra	xai	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury c.			1			
68760,	icate be executed physician and s the buriel-transit	a				i			
687	phy:	edicai	resulting in deeth) Last Due to (or es e consequence of):						
	leeth certific attending p		d						
Box	deeth e atten	Physician/M		ant Dis		A-15 - A- A- A-			
o	es that the de igned by the a be detached to	ıysi	Pert ti. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.	1	V		e cause of death?		
٥	that ded b		PEDTIC UICER DISPOSE	10	Yes 2 No	3 Probeb	ay 4 Unknown		
of Vitai Records,	requires that seen signed b hould be dete	d by		24a, Wes	an autopsy	24b. Were	autopsy findings		
Ö	v raquin been si should	ete	Dementia		ormed?	comp	ble prior to letion of ceuse		
Rec	hes hes	Completed			W.	of dee	_/		
a	definer. The licentificate he rector, page		er will be a first of the second of the seco		Yes 2 No	1 🗆 Y	es 20 No		
5		Be	25. Was case referred to medical exeminer? 1 Yes 2 No						
ot	Physical d	- To	1 Inpatient 2D EN/Outpatient 3D DOA 4D Nursing Ho		how injury occurre				
Division	ding h. After funer	to	27. Menner of Deeth 28a. Dete of Injury 28b. Time of Injury Work? 1 Detailed investigation 28b. Accident 28c. Injury at Work? 1 Yes 2 No		0				
S	Attending or deeth. ector: After by the fune	fica	3 ☐ Sulcide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office	28f. Location	(Street end Numbe	er or Rural R	loute Number,		
	or lefter Direction of the bar of	Certification:	4 ☐ Homlcide building, etc. (Specify)	City or To	iwn, Stete)				
	pours sours veral		29e. Certifier 1☐ Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place,	end due to the	cause(s) end me	nner as state	ed.		
	To the Hospital or Attending I within 24 hours effer deeth. To the Funeral Director: Affer completely filled in by the funer	edical	(Check only one) 2 Medical Sysminer: On the basis of examinetion end/or investigation, in my opinion, deeth occur end mennel stated.						
	of the	Me	29b. Signature and title of certifier / 29c. License number		29d. Dete signed	(Month, Da	y, Year)		
	1		D51908		7/8	190			
	20		30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)		1/4	-			
			David Machina mp 1811 Trace Phill	200	and Ol	nes 1	20		
	Sta	ate	31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture	1		7			
	Reaisti		111 19 1009 Serve B. Sparks						



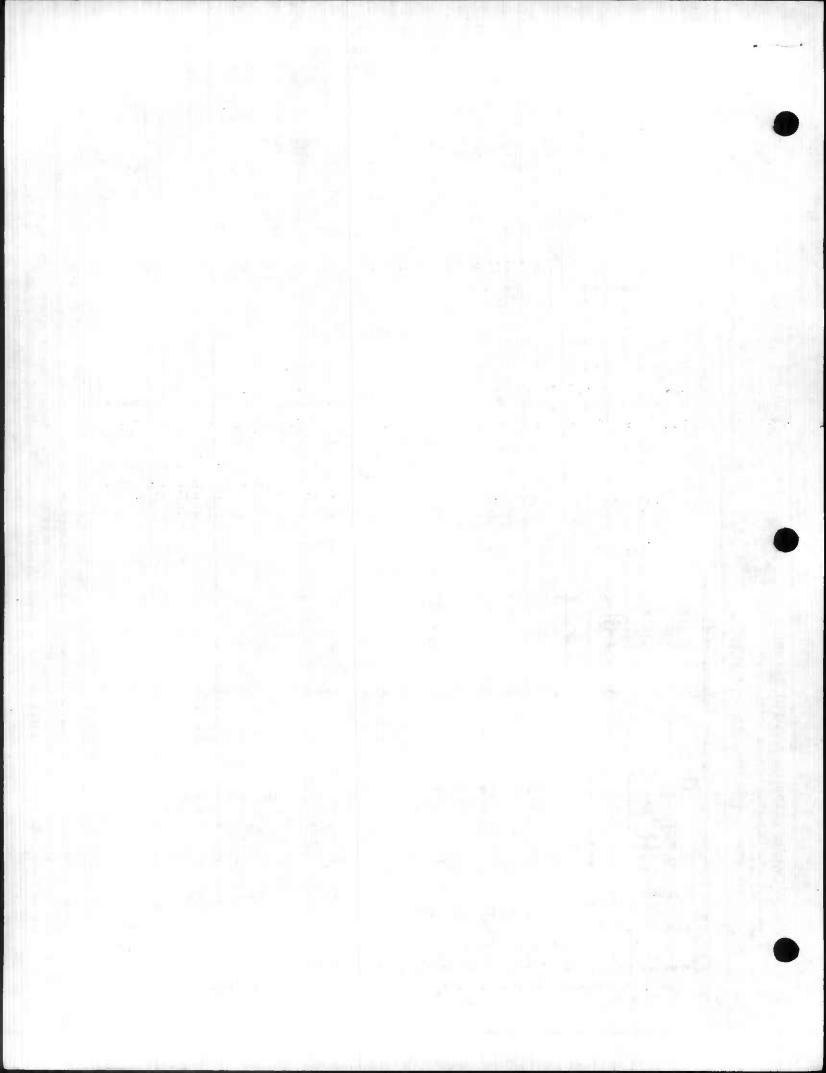
State of Maryland / Department of Health and Mental Hygiene

	<u> </u>	Certificate	of Death	Reg. N	No.	0300			
Physician	1. Decedent's Nama (First, Middla, Last) SAMUEL R	OSEN			Day Yaar	3. Time of Death			
/Medical	4a Facility Neme (If not institution, give street and number)		4b. City, Town, or L	July 5	1999 tc. County of Death	(1. (2))(4)			
Examiner	HEBREW HOME OF GREATER WASH	TNCTON	ROCKVILLE		MONTGOMER	V			
Funeral	5. Sociel Sacurity Number 6. Sex / 7. Aga	(In yrs. last birthday) If Undar 1	Yaer If Undar 24 Hrs.	8. Dete of Birth (Month, Day, Yes		place (Stata or Foreign			
Director	579.22.9871	86 Yrs. Months	Deys Hours Min.	09.10.191	2 ISRA	ĔĹ			
with the Marylend a or 28a-1 show the notified at	10a. Stata 10b. County	10c. City, Town or Location			1	10d. Inside City Limits XXYas 2 □ No			
vith the Maryle or 28s-f short	MARYLAND MONTGOMERY 10e. Street and Number	ROCKVILLE 10f. Zip 0	Coda	100.0	Citizen of What Cour	ntry?			
th with	6121 MONTROSE ROAD	208		US					
	11. Manitel Status 12. Was Decedent Et Armed Forces?		nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto		14. Race - Amaric Bleck, White,				
Dy by	1 Nevar Marriad 2 Married 1 MYss 2 No 1 Yes, Giva Yaer or Datas:	WII 1□ Yas 2		Thous, etc.,	Specify:	HITE			
72 hours natural; edical by	15. Decedant's Education (Specify only highast grada complated)	16a. Decedent's Usuai	Occupation dona during most of work	ing 16b.	Kind of Business/In-	dustry			
1 21215-0 led within 72 ho lygiene. Per than "naturint, the Medical int. Examples Completed	Elamantary/Secondary (0-12) Collega (1-4or 5+	lifa. DO NOT usa	ratired)						
d 2 filled v filled v frher t ent, th	17. Fether's Name (First, Middla, Last)	OWNER	18. Mothar's Nem	GE a (First, Middla, Mald	NERAL STO	RE			
Maryland 2 to 2 should be filed in and Mental Hygi in marked other traumatic avant.	AARON ROSEN		MARY LAI						
Should and Men is marke summic	19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Addrass (Street and Numbar or Rui		y or Town, Stata, Zip	Code)			
1 and 2 1 and 2 Health a sm 27 is	IDA E. ROSEN/WIFE	6111 MONTRO	SE ROAD, RO	CKVILLE, M	ARYLAND	20852			
iore, Maryland Special and 2 should be filed to of Health and Mental Hydron 27 is marked other or other traumatic avant,	20e. Mathod of Disposition 1 Buriai 2 □ Cramation 3 □ Ramoval from Stata	20b. Plece of Disposition (Name cematary, crematory or oth	of ar place)	Deta 20c.	Location - City or To	own, Stete			
E 0822	4 Donation 5 Other (Specify)	MOUNT LEBANON	CEMETERY	7.9.99 AD	ELPHI, MA	RYLAD			
Baltimore, N permit. Pages I and Department of Health Important: If I than 27 any Injury or other ti pncs.	21. Signature of Funeral Service Licensee	EDWARD	Addrass of Fecility SAGEL FUNER			20052			
CONTRACT	23a. Pert1. Entar tha disaasa, or complications that ceusad t shock, or heart failura. List only one ceuse on each line	1091 RC ha daath. Do not antar tha moda	CKVILLE PIKI of dying, such as cardiac	E, ROCKVIL or raspiratory arrest,	LE, MARYL	Approximete			
Physician	shock, or heart failura. List only one ceuse on each line).				Intarval Between Onset and Death			
/Medical	Immediata Causa (Finai diseasa or condition	TROPIC AND	MIA			YGARS			
Examiner	resulting In deeth)	Dua to (or as a consequence of):							
b is e	b								
60, be executed ician and buriel-transit	Sequentially list conditions, if any, leading to immediate	due to (or es a consequance of):							
	Sequentially list conditions, If any leading to immadiate cause. Enter Undarlying Causa (Disaasa or Injury that initiated evants	us to for an a consequence of:							
- 0.0	resulting in death) Lest								
death certification of for use a siclan/Me	d								
. 0 0 0	Part II. Other significant conditions contributing to death but	not rasulting in the underlying ce	use given in Pert I.	23b. Did tobac	co use contribute t	to the causa of death?			
ecords, P.O. Box law requires that the death cert les been signed by the ettending 2 should be detached for use an pleted by Physician/M	ATHERO SCLEROTI	C HEART D	ISEASE	1 Yes	2 No 3□ Pro	babiy 4 Unknown			
rds n sign nd be				24a. Was an au		/era autopsy findings			
w req w red s beer s shot				performed	00	vallebla prior to ompletion of cause daath?			
Vital Record ration: The law requir s certificate has been si director, page 2 should o Be Completed				1□ Yas	2 1 No 11	☐ Yas 2☐ No			
f Vital Re system: The last certificate he director, page	25. Was cesa refarred to medicel		28. Placa of Dea	th (Check only ona)					
Of Vita Physician: this certific ral director,	axaminar? 1 ☐ Yas 2 ☐ No Hospitei: 1 ☐ Inpatien	t 2 ER/Outpatient 3 DOA	Othar: 4 Nursing He	oma 5 Residence	6 □Other (Speci	fy)			
on of ding Phys After this funeral of	27. Mannar of Death 28a. Data of Injury 1 Neturei 5 ☐ Panding (Month, Day		c. Injury at Work?	28d. Dascribe how Ir	njury occurred				
Isio deeth for: A the f	2 Accidant investigation 3 Suicide 6 Could not be 282 Blace of laint	M M	1 ☐ Yas 2 ☐ No	28f. Location (Street	and Number or Pur	rel Bouta Number			
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed by	4 Homicide datarmined 28a. Place of injurbuilding, atc.	y - At homa, farm, straat, factory, (Specify)	Onice	City or Town, St		ar nobla redition,			
spital hours neral y filled	29a. Cartifiar 1 ertifying Physician: To the bast of	my knowledge, daath occurred at	tha tima, deta and place,	and dua to the cause	(s) and manner as a	stated.			
in 24 Ho Fu Fu Fulled	(Check only one) 2 Medicat Examiner: On the basis of a and menner stet.	examination and/or investigation, i ed.	n my opinion, deeth occur	red at tha tima, dete	end piece, and due t	o tha cause(s)			
To the To the Market	29b. Signatura and titla of certifier		Licansa number		Date signed (Month,				
5	P. Zalman, M.D.		D 36552	30	LY 8	1999			
	30. Name and address of person who complated ceusa of dar P. 7 ALWAR 6121	ath (Itam 23a) (Type, Print) Nontrose Ro	ad. foc	kville 1	MD. 208	52			
State	31. Data filed (Month, Day, Year) 32. Registrar		1						
Registrar	JUL 14 1999 > 150	psi p. p.	oouls						



	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.
Physician /Medical	1. Decedent's Name (First, Middle, Last) Granville Mc (Cinley Russell 2. Date of Deeth Month Dey Year 7: 220
Examiner Funeral	4b. City, Town, or Location of Death Novey Medicus Country of Deeth 5. Social Security Number 218-07-1330 6. Sex Yrs. 7. Age (In yrs. last birthday) H Under 1 Yeer H Under 24 Hrs. (Month, Dey, Year) Apr. 24, 1919 9. Birthplece (Stete or Foreign Country) Apr. 24, 1919 9. Birthplece (Stete or Foreign Country) Apr. 24, 1919 9. DELL
Director	Usuel Residence of Decedent
death with the Manyland rms 23e or 28e-f show rms to notified at meral Director	10a. Stete DEL 10b. County 10c. City, Town or Location Bridgeville 10d. Inside City Limit 1 □ Yes 2 № N
with the Mai 3a or 28a-f s if be notified	10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? RTE # 1 Box 222 19933 USA
P 5 5 2	11. Marital Status 12. Wes Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc.
1 21215-0020 ed within 72 hours after ygiene. ver then "natural", or its it, the Medical Examins Completed by Fui	15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) 8 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Dealer Auto/Trucks
Maryland 212: 42 should be filed within th and Mental Hygiene. 71s marked other than traumatic avent, the M To Be Comp	17. Fisher's Name (First, Middle, Last) Elmer J. Russell Sallie Passwaters
Nore, Maryland 21215-6 ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 is marked other than "nature or other traumatic avant, the Madical To Be Completed	19s. Informant's Name/Relationship (Type, Print) Dorothy R. Adams/Daughter 19b. Meiling Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 20e. Method of Disposition 20b. Pleas of Disposition (Name of complete) 20c. Location - City or Town, State (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 21632 20c. Location - City or Town, State 20c. Location - City or Town, State
Baltimore, Me permit. Pages 1 and 2: Department of Health at Important: if Nem 27 is any Injury or other trau any Engle.	A point 2 Cemetery 7/2/99 Federalsburg, MD 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
m 89529	H. Torbert Williamson, per DVR Federalsburg, MD 21632 23a. Perll. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Between interval Between
Sydo, ate be executed thysician and the bunal-transit the bunal-transit dical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) a. Cardiac Arythma Due to (or es a consequence of): Auth Tubular Necros : 5 Dua to (or es e consequence of): Couse, Enter Underlying Ceuse, Disease or injury Couse, Disease or injury
876(sate be shysicia the bur	Ceuse (Diseese or injury that initiated events Due to (or as e consequenca of): resulting in deeth) Last
Phy detay	Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown
Records, le law requires to the second signer of the second signer of the second secon	Chronic Renal Insufficiency 24e. Wes en sutopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of death?
r Vital Re patchen: The last certificate he director, page	25. Wes case referred to predical 28. Place of Deeth (Check only one)
	examiner?
After fune	27. Menney of Deeth 1 Striketurel 5 Pending (Month, Dey Year) 2 Accident Investigation 3 Suicide 6 Could not be
DIVISION To the Hospital or Attant within 24 hours effer deat to the Funeral Director: completely filled in by the Medical Certifical	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)
To the Hospital Within 24 hours To the Funeral I completely filled Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date and place, and due to the cause(s) and mannar as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mennar stated.
within 2 To the comple	29b. Signeture end title of cardiller 29d. Date signed (Month, Day, Year)
	100 712457 July 16, 1999
	30. Nemeral address of forson who complated cause of death (Hem 23a) (Type, Print) Jon Yamaguch 29 I. Greene St. Baltimore mis 2/201
State Registrar	31. Date filed (Month, Day, Year) 32. Registrer's Signeture 33. Aparly 33. Registrer's Signeture

	1. Decedent's Name (First, Middle, L	JW, Montg.	Co.	Certifica	ate of Death	10.00	Reg. No.		a Time	
Physician	Social s Name (First, Middle, L	Lenor	a L	enora So	cott	2. Date of De Month July	Day	Year	3. Time of Deat 6:30AM	
/Medical Examiner	4a Facility Nama (If not institution, gi	ve street and number)			4b. City, Town,	or Location of Deat		,		
	Wilson	Health	10	re	Gaither		Montg	omery		
uneral		Sex 7. Age	(In yrs. last b	Yrs. If Unc	der 1 Year If Under 24 H is Days Hours M	in. 8. Dale of Bir (Month, Da April	th ly, Year)	9. Birthplac Country Mary La	e (State or Fore	
irector	214-24-3818 Usuel Residence of Decedent					Whili	2, 1910	maryra	IId	
ohow sdatt	10a. Stale 10b. County		10c. City, To	wn or Location			10d. Inside City			
otor	Maryland Montgome	ery	Gaith	ersburg					1 Yes 2 3	
23a or 28a-f ehoust be notified at rai Director	10e. Street and Number			10f. 2	Zip Code		10g. Citizen of V	What Country	?	
ms 23s or 28s-f show count be notified at nersi Director	301 Russell Avenu				877		JSA			
r hems 23. obsr. must Funeral	11. Marital Stalus	12. Wes Decedent E Armed Forces?		13, Was Dec	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Rac Blac	e - American ck, White, etc		
0 5	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo	1 🗆 Yes	2⊠ No Specify:		Specify	.White		
	15. Decedent's E		16	a. Decedent's Us			16b. Kind of Bu	usiness/Indus	stry	
	(Specify only highest gr		4)	(Give kind of I life. DO NOT	work done during most of v "use retired)	vorking				
ther then naturally the Completed	Elementary/Secondary (0-12)	Comple (1-401 3		memaker			Own Hom	e		
21 4	17. Father's Name (First, Middle, Last	0)			18. Mother's N	lame (First, Middle	, Maiden Surnan	10)		
umarked or umaric ave To Be						ee Bass				
9 6	19a. Informant's Name/Relationship		1		ess (Street and Number or			State, Zip Co	ode)	
item 27 other tr	Constance N. Puro	cell/ Niece		10 Mount of Disposition (A	tain Road, L	inthicum, Date	MD 210	-	-	
F 9	13DBurial 2 ☐ Cremation 3 [cemet	ery, crematory o	r other place)	Date	20c. Location -	City or Town	, State	
Important: If it any Injury or o	4 Donation 5 Other (Speci	**	00018	Cer	neterv	7/13/99	Adelph:	i, MD		
any lo	21. Signature of Funeral Service Lice	nsee		Franc	ns Funera	1 Home,	Inc.	100 707		
	23a. Pert1. Friter the disease, or con shock, or heart tellure. List only	James			University B.				, MD 20 pproximata	
edical miner	immediate Cause (Final disease or condition resulting in death)	4.	12711 2311	tery Dis				У	ears	
in end fel-transit Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								
ouriel-tran	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Oue to (or as a	consequence o	():			1		
the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflinted events resulting in death) Last	C		consequence o						
the bur	that initiated events	d	Due to (or as a	consequence o	():	23b. Did	tobacco use co	ntribute to th	ne cause of de	
by the attending physicianched for use as the burner of th	Part II. Other significant conditions of	c	Due to (or as a	consequence o	():		tobacco use co Yes 2☑ No			
gned by the attending physicie be detached for usa as the bur by Physician/Medical	resulting in death) Last	c	Due to (or as a	consequence o	():	10	Yes 2⊠ No	3 Probet	oly 4⊡Unkı	
gned by the attending physicie be detached for usa as the bur by Physician/Medical	Part II. Other significant conditions of	c	Due to (or as a	consequence o	():	1 🗆		3 Probet	autopsy findin	
has been signed by the attending physicia pe 2 should be detached for usa as the bur mpleted by Physician/Medical	Part II. Other significant conditions of Congestive Heart	c	Due to (or as a	consequence o	():	1 ☐ 24a. Was perfo	Yes 2 No an autopsy ormed?	3 Probet 24b. Were availa comp of dea	autopsy findin able prior to letion of cause ath?	
ate has been signed by the attending physicia page 2 should be detached for use as the bur Completed by Physician/Medical	Part II. Other significant conditions of Congestive Heart Hypertension	c	Due to (or as a	consequence o	f): g cause given in Part I.	24a. Was perfo	Yes 2 No	3 Probet 24b. Were availa comp of dea	autopsy findin	
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To the Funeral Director: After this certificate has been signed by the attending physicial completely illied in by the funeral director, page 2 should be detached for usa as the but completely illied in by the funeral director, page 2 should be detached for usa as the but completely illied in the standard of the funeral forms and the standard in th	Part II. Other significant conditions of Congestive Heart Hypertension 25. Was case referred to medical examiner? 1	d	t not resulting	outpatient 3 Time of Injury M Jerm, street, fection, dor investigati	26. Place of DOA Other: 28c. Injury at Work? 1 Yes 2 No ory, office ad at the time, date and place, in my opinion, death oc	24a. Was performed at the time,	Yes 2 No an autopsy primed? Yes 2 No one) dence 6 Oth how injury occur (Street and Numb win, Stete) cause(s) and ma date and place, 29d. Date signe	3 Probat 24b. Were availa comp of dea to the comp of dea to the comp of dea to the comp of dea to the comp of dea to the comp of dea to the comp of t	autopsy finding ible prior to letion of cause atth? res 2 No Noute Number, acause(s)	
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	Pieas	se Type or								-	-	ible.		
		State	of Maryla	and / I				lealth a Death		Mental Hy	rgiene Reg. No.		26503	
. Decedent's Nam PAULI		Last)	SALEM							2. Date of Do Month JULY 8	Day	Year	3. Time of Death 12:26 PM	
		give street and no	imber)					4b. City, To		ocation of Dear	h 4c. Coun	ty of Dea		
Social Security N 220-31-7	779	6. Sex 1□ M 2G/F	7. Age (In y		Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D DEC •	av. Year)	9. Bir Co EN	thplace (State or Foreign puntry) GLAND	
sual Residence of Decedent Oa. State 10b. County 10c. C MARYLAND MONTGOMERY					or Loc								10d. Inside City Limits 1 √ Yas 2 □ No	
De. Street and Nui 8211		IAN LANE				10f. Zip	Code 0854				10g. Citizen of UNITED			
1. Marital Status 1 Never Man 3 Widowed	The state of the s	Armed F	2 No	U,S.	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:						14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)				-	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER					sing	16b. Kind of Business/Industry OWN HOME			
7. Father's Name ISAAC	(First, Middle, L. BROWN	ast)								e (First, Middle URMAN	, Maiden Suma	те)	27 . 77 .	
9a. Informant's No	ame/Relationshi		GHTER)		Mailin						MARYLA			

20c. Location - City or Town, State

ALEXANDRIA, VIRGINIA

7/10/99

4s Fscility Name (If not institu

5. Social Security Number

Usual Residence of Deceden

11. Marital Status

10e. Street and Number

17. Fether's Name (First, Mid

20a. Method of Disposition

4 □ Donation 5 □ Other (Specify)

1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1999

32. Registrar's Signature

31. Date filed (Month, Day, Year)

JUL 15

10a, State

Physician

/Medical

Examiner

Director

Be Completed by Funeral

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mentel Hygiene. Important: if hem 71 is marked other than "patural", or hems 23a or 28e-f ahow eny injury or other treumatic event. In a

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

21. Signature of Funeral Service Lie **Somalal C.**	0-	22. Name and EDWAR	Address of Facility SAGEL FUN ROCKVILLE P	ERAL DIRECTION,	INC. MARYLAND 20852	
23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the property one cause on each line.	th. Do not enter the mode	of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)	aCARCINOM	3 YEARS				
	Due to (or as a consequence of):				
	DIABETES	5 YEARS				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			1	
Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (d	or as a consequence of):				
	■ d					
25. Was case referred to medical				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
examiner?	Hospital:		Other	eath (Check only one)		
1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigal	28a. Date of Injury (Month, Day Year)	BR/Outpatient 3 DO 28b. Time of Injury M	Home 5K Residence 6 □0 28d. Describe how injury occ			
3 Suicide 6 Could no determin	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of my known arminer: On the basis of examinating and manner stated.	owiedge, death occurred eation and/or investigation,	t the time, date and plac in my opinion, death occ	e, and due to the cause(s) and rurred at the time, date and place	manner as stated. e, and due to tha cause(s)	
29b. Signature and title of pertifier	1 1	29c.	License number	29d. Date sign	ned (Month, Day, Year)	
Mohe	et J. / Mide	4. 0	D06333	JULY 8	3, 1999	

20b. Place of Disposition (Name of cemetery, cremetory or other place)

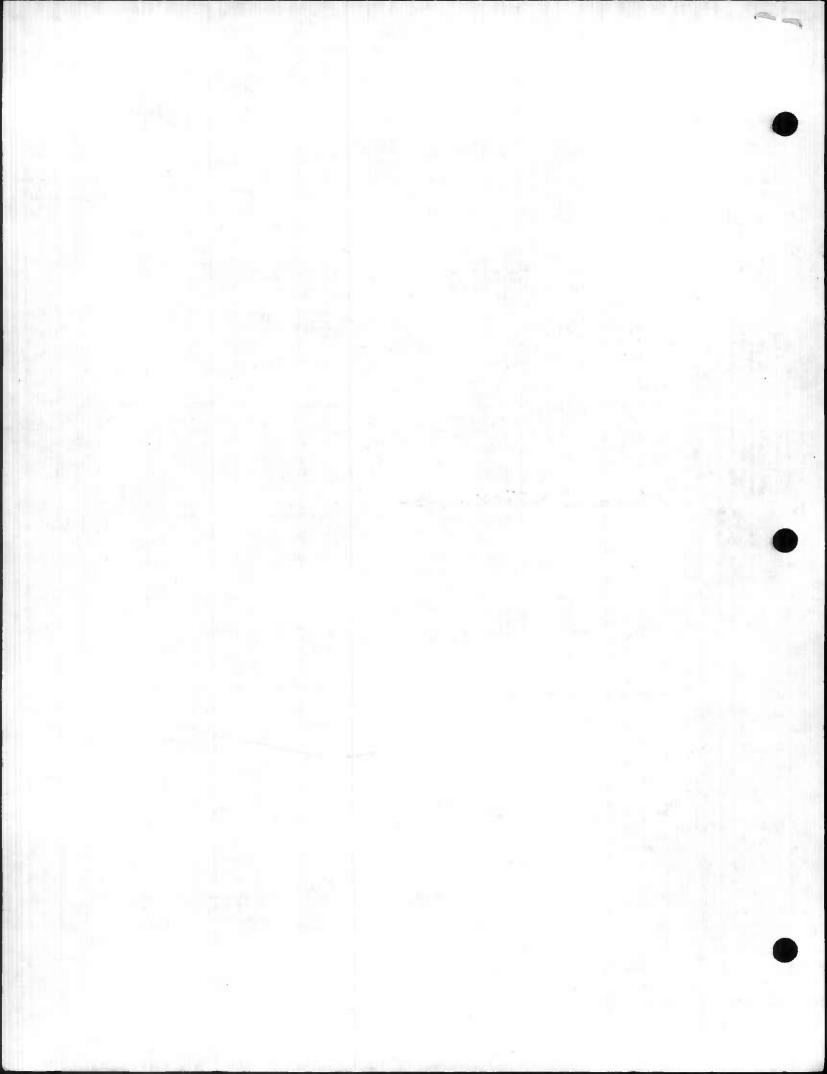
MT. COMFORT CREMATORY

DHMH 16 Rev 6/95

State

Registrar

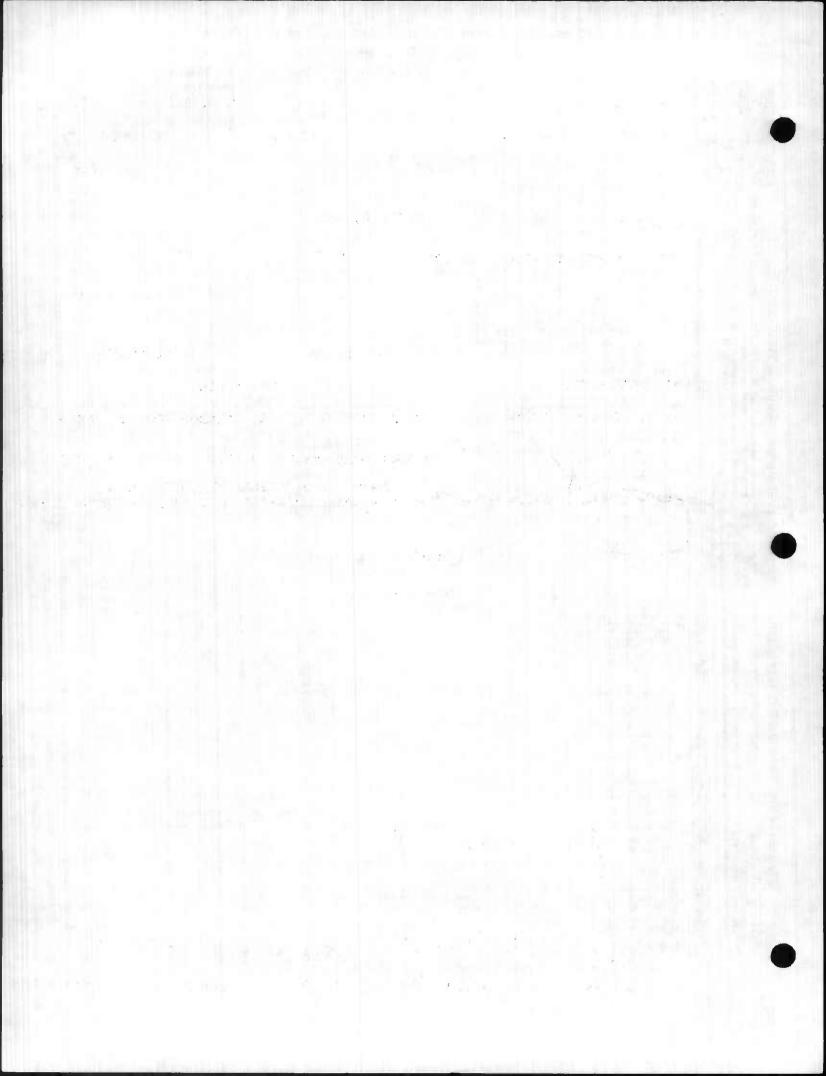
ROBERT J. LINDERMAN - 10215 FERNWOOD ROAD # 100 - BETHESDA, MARYLAND 20817



State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death		Reg. No.	-	000	
Physician	1. Decedent'a Name (First, Middle, L	ast)				2, Data of D		Year	3. Time of Death	
/Medical	MIRIAM SCHACHTER								5:30 AM	
Examiner	4a Facility Name (If not institution, g MANOR CARE NURS!				BETHESD		of Death 4c. County of Death MONTGOMERY			
72 hours after death with the Manyland natural, or items 23s or 28s-f show sound and the Examiner must be notified at open attention of the contract of the co	5. Social Security Number 6. 056.16.3214 Usual Residence of Decedant	Sax 7. Aga (h	n yrs. last birthda 80 Yrs.	Montha Day			ay, Year)	9. Birthp Coun NEW Y	lace (Stata or Foreigi (N) ORK	
	10a. State 10b. County	1	0d. Inside City Limits							
	N/A	N/A	WASHIN	VGTON, D.	C.				1 to Yes 2 □ No	
	10e. Street and Number 5420 CONNECTICU	r Avenue, nw	#306	10f. Zip Code 200			10g. Citizen of N USA	What Coun	itry?	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		3. Was Decedent of If Yas, specify Cu		(Specify Yes or Narto Ricen, atc.)	o- 14. Rac Blac Specify	e - Amaricok, Whita,		
ed within 72 hours a vglene. or than "natural", o rt, tre Medical Exe Completed by	15. Decedent's I (Specify only highest g	Education rade completed)	(G)	cedent's Usual Occi	e during most of w	vorking	16b. Kind of B	usiness/Inc	dustry	
mpk	Elementary/Secondary (0-12)	College (1-4or 5+)	life	e. DO NOT use retir	red)					
Per the	17. Father's Name (First, Middle, Las	-		STATISTIC:	1	lama (First, Middl	US GOVE		r	
Mental H Mental H arked out artic ever	MOSES SCHACHTER	4)				IE ALTMAI		ray		
nd 2 short alth and N 27 is main resume	19a. Informant's Name/Relationship JOSEPH SCHACHTER			elling Address (Stree 20 ORCHARI					Code) 20878	
permit. Pages 1 and 2 should be filed within 72 hours begarment of Health and Mantal Hyglene. important: If them 27 is marked other than "netural; any injury or other traumatic event, the Medical Exa page. To Be Completed by	20a. Method of Disposition 1 Burial 2 Cramation 3/ 4 Donation 5 Other (Spot 21. Signature of Funer Servic Lice	Femoval from State	cametery, c	sposition (Nama of crematory or other po CORT CREMA 22. Name end Add EDWARD SA	ATORY ress of Facility	7.13.99		DRIA,	vun, Stata VIRGINIA	
certificate be assecuted dring physician and use as the buriel-transit and wheeling the world of the control of	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	b. Due	e to (or as a cons	sequence of):						
death e atter ed for	Part II. Other algnificant conditions	contributing to death but n	ot resulting In the	a underlying cause (givan in Part I.				o the cause of death	
med be dete						-	Yes 2127No	s 227No 3 Probably 4 Unknow		
law requires that the as been signed by the 2 should be detached princed by Phys					24a. Wa per	s an autopsy formed?	av co	ere autopsy findings ailable prior to mpletion of cause death?		
The law sta has page 2						1 🗆	Yes 20 No	18	Yes 22No	
ysician: The list certificeta he director, page	25. Wes case referred to medical examiner?				26. Place of C	Death (Check only	one)			
Physician: this certific ral director, To Be (1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpa	tient 3LJ DOA		Homa 5□Re			y)	
To the Heaptai or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide Could not determine	be 200 Place of level	Time of Injury at Work? M 1 Yes 2 No 28d. Describe how Injury of				occurred Number or Rural Route Number,			
Hospital or 24 hours afta 24 hours afta Funeral Dire stely filled in Alcal Cert	4 Homicide 29a. Certifier (Check only) Medical Exp	hystolan: To the best of m	ny knowledge, de	eath occurred at the	time, date and pla	ice, and due to th	e ceuse(s) end m	anner as s	itated.	
To the Hospi within 24 hour To the Funer completely fil	29b. Signature and Ittle of certifier	iminer: On the basic of exa and mannar taled		29c. Lice	nse number	Auti en je berius	29d. Date signe	ed (Month,	Day, Year)	
-	30. Nama and address of person who	completed ceuse of death				TRRRA	23 Cr (282	nurion	UU NA 2085	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Spar	h					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth De **Physician** GRANT Н. SHELDON JULY 12,1999 4:20 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MARINER HEALTH CARE OF SILVER SPRING SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Dete of Birth
(Month, Day, Year)
APRIL 23,1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 1XXM 2 F Months NEW YORK 579-20-1861 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Directo SILVER SPRING MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 UNITED STATES 1600 DENNIS AVENUE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1XXYes 2□No If Yes, Give Year or Detes: 1945-46 1 ☐ Yes 2 ∑No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HEATING AND AIR Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED CONDITIONING 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 8 MYRTLE DUNN SHELDON HOWARD G. 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SILVER SPRING, MARYLAND CATHERINE B. SHELDON/SPOUSE 1600 DENNIS AVENUE 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Puriat 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify) 7-15-99 LAYTONSVILLE,MD LAYTONSVILLE CEMETERY 21. Sig 22. Neme and Address of Fecility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 Approximate tnterval Between Onset and Daeth 23a. Part1. Enter the disease, or complications net caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one offuse on each tine. Immediate Cause (Final disease or condition resulting in death) MINUTES ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes ZXINo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pteca of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertified JULY 13,1999 D 09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar BARRY N. ROSENBAUM, M.D.

939 egistrar's Syneture

31. Date filed (Month, Day, Year)

Funeral

Director

notified at ehom

the Meryland

permit. Pages 1 and 2 ahould be filed within 72 hours after death with t Department of Health and Mental Hygiens. Important: if Nem 27 is marked other than "natural", or Nems 23a or 2 eny Injury or other treumatic avent, the Medical Experiments 25a or 2008.

Physician

Examiner

use as the burlel-transit

page 2 should

certificate has

After this

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To the Hospital of within 24 hours of To the Funeral C completely fitted Hospital

funeral

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or Attending Physician:

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The lew requires that the death certificate be avacuted

Box 68760.

P.O.

of Vital Records,

Division

/Medical

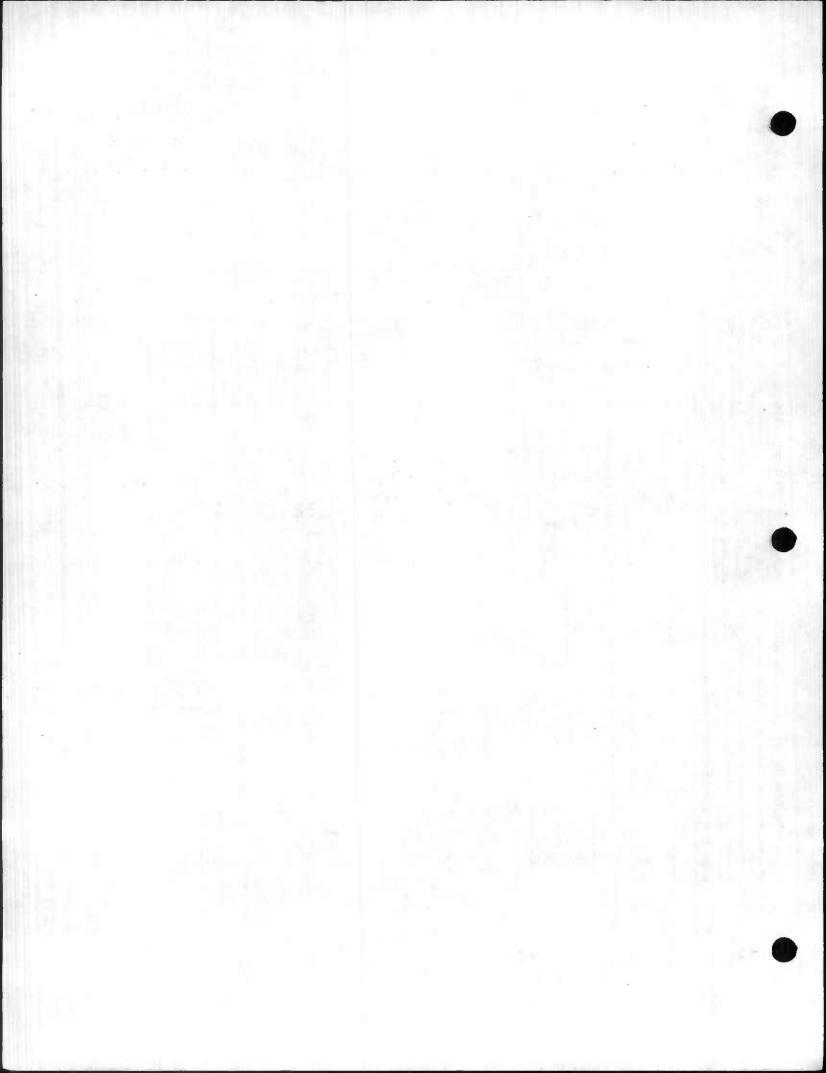
Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

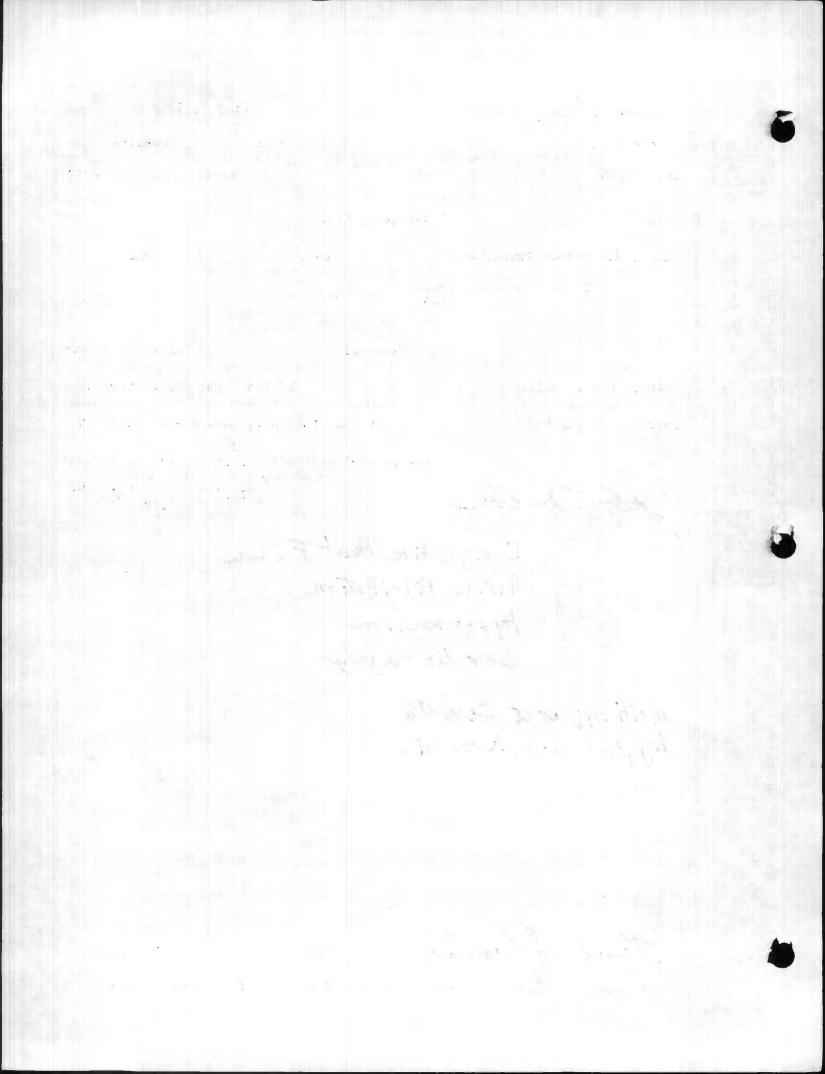
3720 FARRAGUT AVENUE

20895

KENSINGTON, MARYLAND



	Certificate of Dea	eath	Re	g. No.	1	2.470	
Physician	Decedent'a Neme (First, Middle, Last)		Dele of Deeth Month	Dey	Year	3. Time of	Death
/Medical	Arthur Jensen Smith		1y 7,	1999		8:37	PM
Examiner		City, Town, or Location	on of Deeth	4c. County			
	5. Sociel Security Number 6. Sex 7. Age (In vrs. last birthdev) If Under 1 Year If U	aldorf Under 24 Hrs. 8, p	Dete of Birth Month, Day,	Char		oce (Stete o	or Fore
uneral irector	141-14-5468 1M 2 F 79 Yrs. Months Deys Ho	lours Min. (Month, Day, ay 26,	1920	New J	y) Tersey	y
bygiene. thygiene. the Medical Executes must be notified at the Medical Executes must be notified at Completed by Funeral Director	Usuel Residence of Decedent						
	10a. Stete 10b. County 10c. City, Town or Location				10	d. inside C	
	none none Washington, D.C. 10e. Street and Number 10f. Zip Code		10	g. Citizen of V	What County		
	4313 Embassy Park Dr., N.W. 20016	6		USA		,	
	11. Maritel Status 12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispen		Yes or No-	14. Rec	e - America		
b y	1 Never Married 2N Merried 1 N Yes 2 No 1943	Aexican, Puerto Rica Specify:	n, etc.)	Specify	k, White, e	ite	
natural, solcal Exe leted by	15. Decedent's Education 16e. Decedent's Usual Occupation	n na most of undring	1	16b. Kind of Bu	sineas/Indu	atry	
	(Specify only highest grade completed) [Give kind of work done during life. DO NOT use retired) [Elementery/Secondary (0-12) Collaga (1-4or 5+)	ig most of working		74 - 4 - D			
S P	5+ Diplomat	11-11-1-1-1-1-1		State D	•	ment	
rtic event, the Medical I	17. Father's Name (First, Middla, Last) Arthur Mialo Smith	. Mother's Nama (Fin	Chris		_{e)} Camer	O.D.	
To Be Comp	19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addresa (Street end I						
other traumatic event, the M	Patricia Smith/ Wife 4313 Embassy Pa						
other tr	20e. Method of Disposition 20b. Place of Disposition (Name of	. D	ete 2	20c. Location -			
± 6 ±	1 □ Buriel 2 🖾 Cremetion 3 □ Removal from Stete 4 □ Donetion 5 □ Other (Specify) Metropolitan Cremetery		y 8,	Alex.	, Vir	ginia	
Important: If it any Injury or o	21. Signatur of Funeral Service Licenses 22. Name end Address of	Fecility DeVol	Funer	isin Av	e., N	. W.	
Importan any Injur once.	23a. 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, su nock, or heart failure. List only one cause on each line.			D.C.		Approxime	to
ed by the ettending physician and deteched for use as the bunat-transit of the physician/Medical Examiner	Immediate Couse (Finet disease or condition resulting in daeth) Sequentially list conditions, it any, leading to immediate causa. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Can dio megaly Car dio megaly	tai lure					
the eff thed fo	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Pert I.	23b. Did to	bacco uaa co	ntribute to	the cause	of de
d by Jetacl	Multi infarct Dementia		1 🗆 Ye	s 2 No	3 Prob	ably 4 🛚	Unk
should be	Multi infarct Dementia hy per choles terolemia			performed?		re autopsy iteble prior apletion of a ath?	to
a has	V /		1□ Ye	s 2K No	-	Yes 2	
certificata ha rector, page Be Com	25. Was case referred to medical 28.	B. Place of Death (C)			1	105 2	1140
direct direct O	examinar?	4 ☑ Nursing Home			er (Specify)	
r: After this e funeral di atlon: To	27. Menner of Deeth 1 Natural 5 ☐ Pending 28e. Data of Injury (Month, Dey Year) 28b. Time of logicy Work? 28c. Injury et Work?	0.00	28d. Describe how injury occurred				
Directo d in by th	3 ☐ Sulcide 4 ☐ Homicida 6 ☐ Could not be datarminad 28a. Placa of Injury - At homa, farm, atreet, factory, office building, etc. (Specify)		Location (St. City or Town	reet and Numb , State)	er or Rural	Route Nun	nber,
4 hours Funeral saly filled Ical Co	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, described on the desired of the time, described on the desired of the time, described on the desired of the time, described on the time,	dete end piece, end on, death occurred e	due to the ca t tha time, da	use(s) and me ata end place,	enner as ste and due to	ated. the ceuse(s)
e Funer pletaly fil		ımhor	25	9d. Date signe	d (Month, L	Day, Year)	
To the Funeral Director: Africompletaly filled in by the fun	29b. Signeture and title of certifier 29c. License nur 29c. License nur 29c. License nur 29c. License nur 29c. Print)			July 8	3, 199	9	
To the Funer completely fil	Taul Stanuin D-4509	92	ederio				



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYL	AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be	2 hours after death with the State Dent, of Health and Mental Hydiene prior to burial, Cremation, or removal.
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	OR	SHICK STATES	COLLEGE
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į	1. DECEDENT'S NAME (First, Middle, Last)		_						MONTH	OF OEATH	AY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	Mildred 5. SEX		yrs. lest birthday)		1 VEAR	IE (MOE	R 24 HRS.	7. DATE		10,19		IPLACE (State or Foreign
	579-18-4790	1 M 2 TF		79 YRS.	MONTHS	DAYS	HOURS	MIN.	(Month	22,	1020	Countr	γ)
	9a. FACILITY NAME (If not institution, give s	treet and number)		13	9b. CITY	, TOWN	OR LOCAT	IDN OF D		22,		NTY OF O	
e l	Collingswood Nurs	sing Cen	ter		Re	ockv	ille				Mo	ntgo	omery
RECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c, CI	TY, TOWN (OR LOCA	TION						10d, INSIDE CITY
8	Maryland Mont	gomery		S	ilvei	Sp	rino						LIMITS? 1 YES 2 NO
4	10e, STREET AND NUMBER	7					f. ZIP COL	E			10g. CITI	ZEN OF V	VHAT COUNTRY?
监 II	11417 Tarpon Ter	race					2090	5			Unit	ed S	States
P. P.	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDED FDRCES?	1 YES	2 X NO					NIC ORIGIN an, Puerto F	? (Specify Yellican, etc.)	or No-	14. RACE Black	E — American Indian, k, White, etc.
à	3 X Widowed 4 Divorced	IF YES, GIVE	WAR OR DAT	ES		1 TYES	2 X NO	Specif	ly:			Spec	White
	15. OECEOENT'S EDU (Specify only highest grade	CATION completed)	1	16a. OECEDENT'				lna	16b.	KINO OF BU	SINESS/INC	USTRY	***************************************
	Elementary/Secondary (0-12)	College (1-4 or 5	+)	ille. Do NOT	use retired.)	dang m	DOLON WORK						
COMPLET		2		Librar	ian					olleg			
	17. FATHER'S NAME (First, Middle, Last)	1 1					120000			fiddle, Maiden	Surname)		
8	Lester Lee Yowell 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									Code)			
2	198. INFORMANT'S NAME (Type/Print) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin O. Smith (son) Same as 10												
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cy Cremation 3 Rem	oval from State		PLACE AND DA			(Name		DATI	20c. LC	CATION -	City or To	wn, State
- [4 Donation 8 Other (Specify)			esapeak	e Cre	mat				2 Bel	tsvil	1e,	Maryland
1	21. SIGNATURE OF FUNERAL SERVICE LIN	ZENSEE /					Fun			ices,	P. A	١.	
	Men W	, Ka	P										MD 20910
	23. PART i. Enter the diseeses, or ahock, or heart feilure.				not entar	tha me	ode of d	ying, suc	ch as card	liac or resp	iratory an	rest,	Approximate interval Betw
	IMMEDIATE CAUSE (Final	My		Int	Int	GIAC	Tian						Onset and De
ŀ	IMMEDIATE CAUSE (Final disease or condition resulting in death) Myo cardial Infarction Due to (or as a consequence or):												5 MINU
,			J (ON NO A V	DONSEGUENCE	orj.								
2	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A	CONSEQUENCE	OF):								-
<u>র</u> ∥	cause. Enter UNDERLYING CAUSE (Disease or injury												
RTIFICATION	that initisted events resulting in death) LAST	OUE TO	O (OR AS A C	CONSEQUENCE	OF):								
병		d											
A.	PART ii. Other significant condition						ng ceuse	given in	Part i.	24a. WAS AF PERFO	AUTOPSY RMEO?	246	WERE AUTOPSY FINDS AVAILABLE PRIOR TO
EDICAL		Alzhe	mer	s iten	1017	a			—	1 TYES	2 1 NO		OF DEATH?
Z									—				1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL		-	-		26. F	LACE OF	DEATH /C	heck only on	e)			
SICIAN	EXAMINER? 1 YES 2 NO	HOSPITAL:	☐ ER/Outpe	tient 3 DOA	OTHE	R:			8 🗆 Othe				
主	27. MANNER OF DEATH	26e. DATE C		28b. T	ME OF	28c. IN	JURY AT			CRIBE HOW	INJURY OC	CUREO	
ВУ Р	1 Natural 6 Pending 2 Accident Investigation	(IIIO),III,	Day, Toury		M		YES 2	□ NO					
0	3 Suicide 6 Could not be		OF INJURY -	— At home, farm	, street, fac	tory, offi	CO			ATION (Street or Town, State		r or Rural	Route Number,
ETE					_								
MPLE	(Check only one)												
S	2 MEDICAL EXAMIN		examination	and/or investige	tion, in my	opinion,	death occ	ured at the	e time, date	and place, a			
BE	29b. SIGNATURE AND TYPLE OF CERTIFIE	nul.		7				CENSE NU				E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CA	IRE OF DEA	TH (ITEM 27) (5:	na Pelesti					I tom			10, 1999
- 0	15201 Shady	TO COM SETENCE	O DEA		ou, i inte	0	Drev	C13/1	. 00	1 70 1	TI. I		

oaks

15201 Shady Grove Road

32. REGISTRAR'S SIGNATURE General

31. DATE FILED (Month, Day, Year)

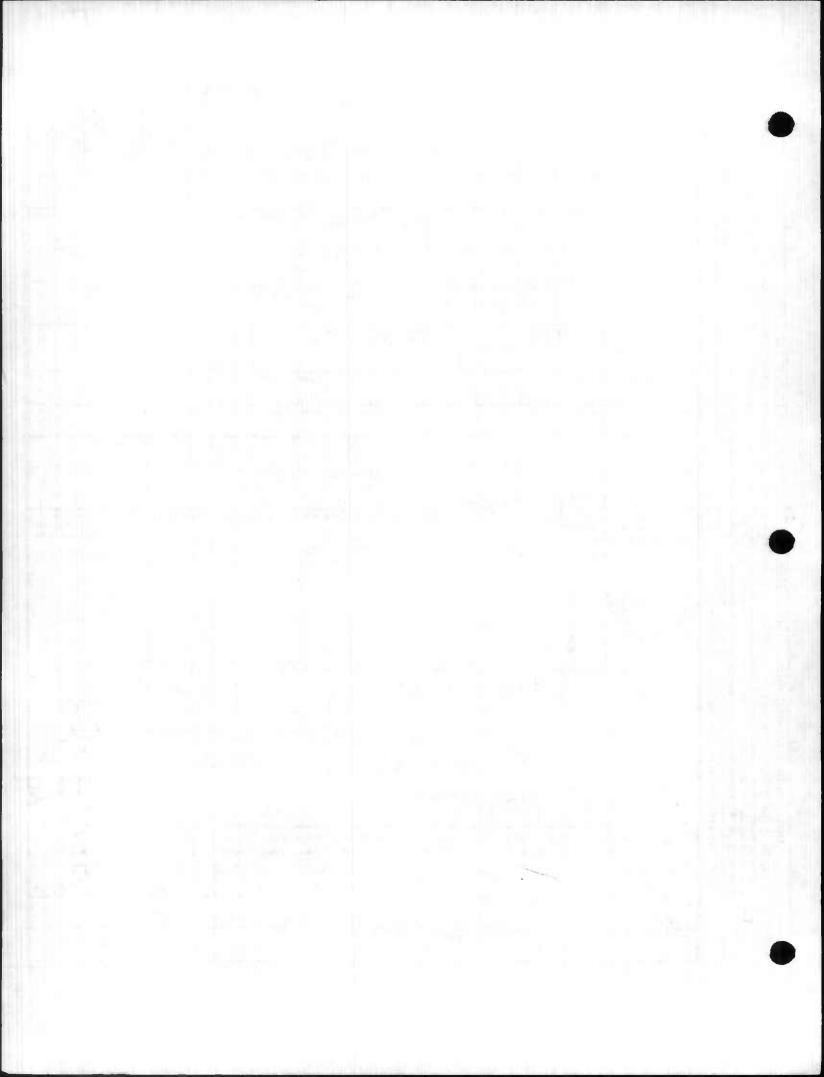
JUL 12 1999

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

3. TIME OF DEATH 4:30 AM M

Approximate interval Between **Onset and Death** 5 minutes

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO

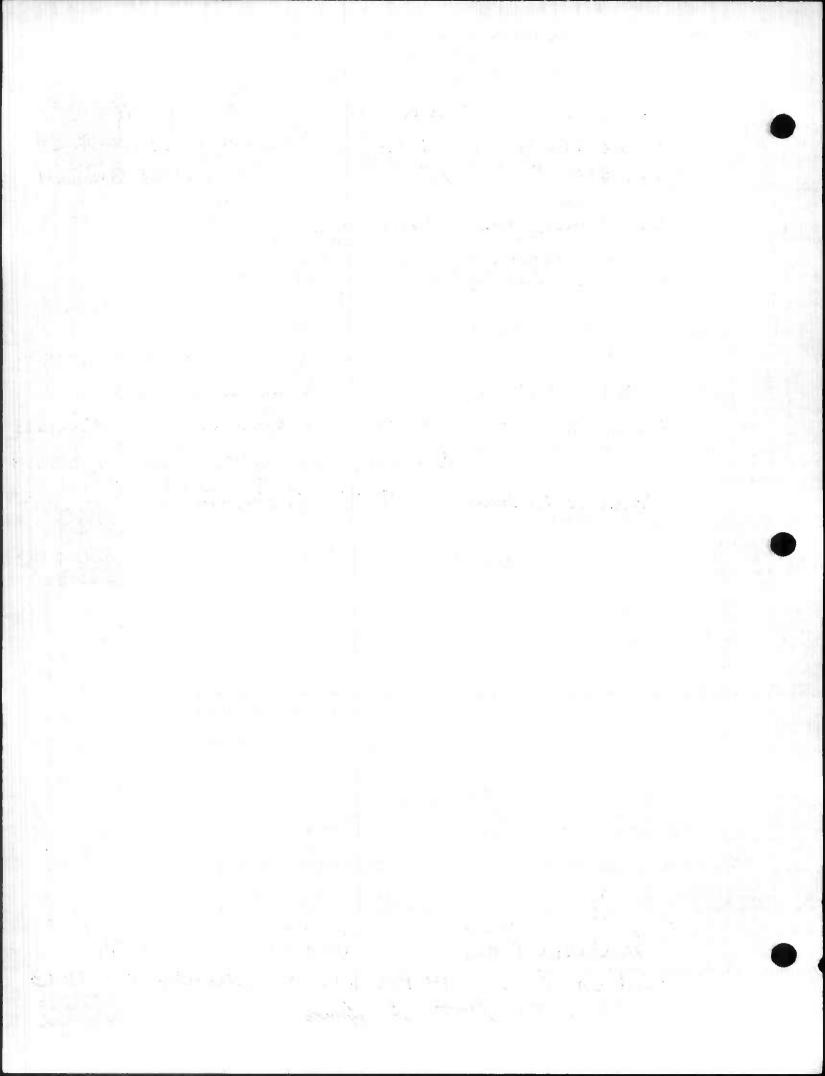


State of Maryland / Department of Health and Mental Hygiene

Discovery from the standard of beautiful programs of the standard of b						Certificate of	Death	Reg. (No.	19999
Function Function		Dhusia		1. Decedant's Nama (First, Middla, Last)				2. Data of Death		3. Time of Death
Examined A. Cooling hases gind institution, pive sized and number)				Mildred Golf -	STANS bury					0 709
Social Social	Š			4a. Fecility Nama (If not institution, give street an	d number)	4		-		
Social Social	7			FAUSTON GEN HOS	0.		FAILS-tox	1	HOPFORI)
District Black Control		Funeral					If Under 24 Hrs.	B. Data of Birth		
106. State 106. Cycley 106. Cycley 106. Cycley 106. Cycley 107. Cycley 108. Cycles of What County? 107. Cycles 108. Cycles of What County? 108. Cycles of What Co	н			202-22-0433 10 M 2	F 22	Yrs. Months Days	Hours Min.	(Month, Dey, Yea	2 Cou	
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Tenther's Name (Pint, Middle, Lad) Tenther's Name (Pint, Middle, Lad)		e M	cto	MU HARFORD	BELA	PIR				Yes 2□No
Tenther's Name (Pint, Middle, Lad) Tenther's Name (Pint, Middle, Lad)		or 28	Sire	10e. Street and Number		10f. Zip Coda		10g. (Citizen of What Cou	ntry?
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17, Father's Name (First Middle, Last) 18. Mother's Rank 1924. Mother's Last 1924 1925 1		W. C. L. S.	Ö	12 5	+ 16	ACHEK		PB	iblic Sci	1001
Physician Phys	2		Be	- 11 11 11			18. Mothar's Nama	First, Middle, Maid	en Sumama)	
20. Reprod of Disposition (Plams of Disposition (Plams of Disposition) (Plams of Dispositio	XIa		2	CHRL HRNAN GOL	'E		BAKNIE	60C	ALLO	WAY
20. Reprod of Disposition (Plams of Disposition (Plams of Disposition) (Plams of Dispositio	a	O1 00 00 00		A		. Mailing Addrass (Street	and Number or Rural	Route Number, Cit	or Town, State, Zij	o Coda)
Description of Superior Control State Community Communit	-	end ealth n 27		KUSSELL STANSBURY	-HUSDAUN 15	11 Westmi	Notel C.	T Bel A.	R MD 2	21014
Physician //Microscopy Physician //Microscopy	ore	ther the		- /		Disposition (Nama of y, cramatory or other pled	e) .	Data 20c.	Location - City or Tr	own, Steta
Physician //Microscopy Physician //Microscopy	Ē	Pag nent int: h			Below	MEIN GOOD	Low 71	499 RE	100	M
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Pinyalician Madical Examiner We must be a consequence of the conditions as consequence of the conditions as a consequence of the conditions as a consequence of the conditions as a consequence of the conditions as a consequence of the conditions as a consequence of the conditions as a consequence of the conditions as a consequence of the conditions are conditions are consequence of the conditions are conditions as a consequence of the conditions are conditions are conditions are conditions are conditions are consequence of the conditions are conditions. 25. When conditions are conditions are conditions are conditions are conditions are conditions are conditions are conditions. 26. Place of Death (Check only one) 10 years 20 years of the conditions are conditions are conditions are conditions. 27. When conditions are conditions are conditions are conditions are conditions are conditions. 28. When are conditions are conditio	m	88 5 8		Lines. H		OFFICE TAIL	era young	or not	1110	
Physician (Modical Examiner) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to the cause of death; III Part III					net caused tha daath. Do r	not anter tha moda of dyin	g, such as cerdiac or	raspiratory arrast.	2018	Approximata
Model Call Examiner Model Call Examiner		Physician		snock, or neert failure. List only one cause	on each line.					intarval Between
Due to (or as a consequence of): Sequentially list conditions, are larger of the property o	Ĭ				15- 11	1 4	1-1-11	A		201
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Marylar		ate of Death		eg. No.		
	Dhusis		1. Decedent's Nama (First, Middla, Last	"			2. Data of Deat Month		Yaar 3.	. Time of Death
	Physici /Medi		Moses		er J	R.	07	08	19	1620
	Examin Funeral Director	ner	1110-18-04771	General 7. Aga (In yrs.	Hospit last birthday If Und Yrs. Month	a Camb		Year)	CheS7 9. Birthplace Country)	Ferz (State or Foreign
, –	and		Usual Rasidance of Dacedant 10a, Stata 10b, County	10c. Ci	ty, Town or Location)		Inside City Limits
1	the Merylar 28a-f show	tor	MD Dorch	octor 1	Cambr.	100				1⊉Yes 2□No
3	or 28e	lrec	10e. Street and Number	63161	101.	Zip Optia	1	0g. Citizen of W	hat Country?	
3	23a	ral	111-GREEN		nue	21613		745	A	
Maryland 21215-0020	be filed within 72 hours after death with the Meryland ital Hygiene. I other than "natural", or items 23a or 28a-f show evert, the Medical Esponder must be notified at	by Funeral Director	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas:		cedant of Hispanic Origin? (S pecify Cuban, Maxican, Puar 2012 No Specify:	Specify Yas or No- to Rican, atc.)	14. Race Black Specify:	Amarican in K., Whita, atc.	ndian,
5-0	"natural",	eted	15. Decedant's Edu (Specify only highast grad	cation (a completed)	16a. Decedant's U	sual Occupation work dona during most of wo	nkina	16b. Kind of Bus		
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d 2	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the M	Be Completed	17. Father's Name (First, Middle, Last)		Mec		ma (First, Middle, M	Rucki Maiden Sumama		Mrany
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Mar	d 2 should be filed within the and Mental Hygiene. 7 is marked other than traumatic event, the Mental traumatic event, the Mental traumatic event.		19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailing Addre	ess (Street and Number of R	ural Routa Number	City or Town,	Stata, Zip Coo	1e)
	1 an Haali em 2		20a. Method of Disposition	CER 20b.1	Place of Disposition (/	Vama of	hue Cal	MBRI dg	-)121613 Stata
mo m	80 -		1 ☐ Burial 2 D Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State	ematary, crematory of MbRidge	e CREMA FORU	7/14/99	a.	,	MD. 211.13
Baltimore,	permit. Pag Department Important: I any Injury o	İ	21. Signature of Funarai Sarvice Licens			and Addrass of Facility	Home	-anbr	· ug cy	MAININI
m	Ped Copy		Janelle C	. Henry	510 W	Ry Funeral		pridge	MD	.21613
٥			23a. Part f. Entar tha diseasa, or compi shock, or haart fallura. List only or	ications that caused the deal na cause on each line.	h. Do not antar tha m	noda of dying, such as cardia	c or respiratory arre	est,	Api	proximate arval Between set and Death
	Physician /Medical Examiner		immediata Causa (Final disaasa or condition resulting in death)		atic 6	aitric Cai	nar		2	weeks
	po 45	niner		b						
60,	icate be executed physician and s the burial-transit	al Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Dua to (d	or as a consequance c	of):			i	
Box 68760,	certif nding usa a	in/Medical	trial inflicted events resulting in death) Last	Due to (c	r as a consequence o	rf):				
O. B	a death he atte	Physician/M	Part ii. Other algnificant conditions cor	ntributing to death but not res	uiting in tha undarlyln	g causa given in Part I.	23b. Dld to	bacco use con	tribute to the	cause of death?
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Vita	cartificata inector, pag	Be C	25. Was casa refarred to medical examiner?	lospitai:		Othor	ath (Check only on			
10	a Physical discountries	n: To	27. Mannar of Death	28a. Date of Injury	28b. Tima of	DOA 4 Nursing 8 28c. Injury at Work?	Home 5 Reside			
Division	Attending Physician: It death. ector: After this cartific by the funeral director,	Certification:	1 Natural 5 Pending invastigation 3 Suicida 6 Could not be datamined	(Month, Day Year) 28e. Place of Injury - At h	injury M oma, farm, street, fact	1 Yas 2 No	28f. Location (St		or or Rural Ro	ruta Number,
Ö	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fo	i Cert	4 D nomicida	bullding, atc. (Special	ý) 		City or Towr			
	Hos 124 h Fun Hataly	edical		ner: On the best of my kno ner: On the basis of axamina and mannar stated.	wieoga, daath occurre tion and/or invastigati	ed at the time, date and place on, in my opinion, death occu	e, and due to tha ca urred at tha tima, da	ausa(s) and mar ata and place, a	ner as stated nd dua to tha	L Cause(s)
	To the comple	Me	29b. Signature and title of certifiar	2 -		29c. Licansa number	2	9d. Data signed	(Month, Day	Year)
			William	- Den	a 22a) (Time Salar)	143238		7/8/	99	
			30. Name and address of person who ca	mplated causa of death (Itar	4 Man	klin X. (ambn	dge, 0	no a	21613
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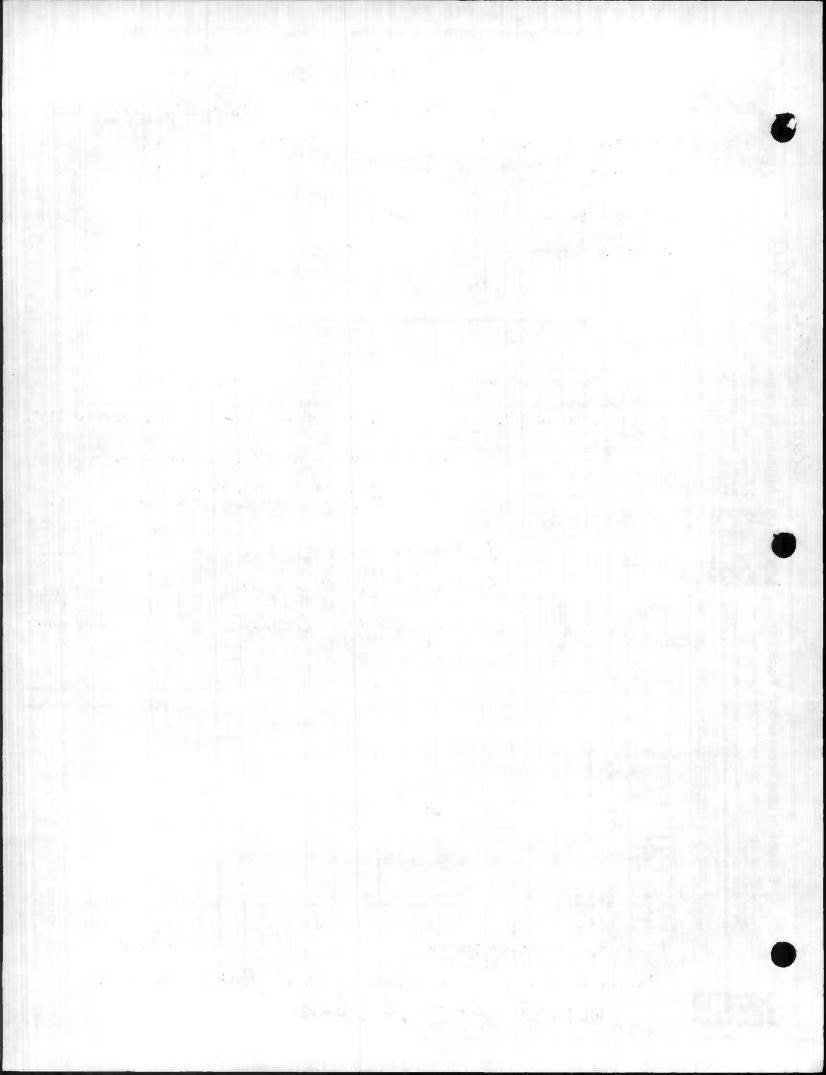
State of Maryland / Department of Health and Mental Hygiene

				Certificate	e of	Death		Re	g. No.	-	00.10	
	1. Decedant's Name (First, Middl	a, Last)						2. Date of Deat		Vaar	3. Tima of Death	
Physician	(B)	Austin	Norma	an Ste	ee1	е		Month J11 V	Day	Year 1999	1312	
/Medical	4a Fecility Nama (If not institution						n, or Lo	ocation of Death	4c. County		1312	
Examiner	The Memorial	The state of the s				East	on		Tall	oot.		
Summer	5. Social Security Number		n yrs. last birt	hday) If Undar		r if Undar 2	4 Hrs.	8. Data of Birth		9. Birthpi	aca (Stata or Foreign	
Funeral Director	049-07-6286 Usuat Rasidance of Decedent	XXM 2□F 89		rs. Months	Days	Hours	Min.	May 7,	1910	Coun	York	
and land	10a. Steta 10b. County	11	Oc. City, Town	or Location						10	Od. Insida City Limits	
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vith the Ma t or 28a-f s be notified Director	10e. Street and Number			10f. Zip	Coda	,		1	Og. Citizan of	What Coun	try?	
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or its	11. Meritei Status 1 ☐ Navar Married 2 ☐ Meri 3 ☒ Widowed 4 ☐ Divorced	If Yas Giva	er in U,S.	13. Was Deced if Yes, spec	ify Cu	ban, Mexican,	in? (Sp Puarto	ecify Yas or No- Rican, etc.)		ck, White, i		
2 should be illed within 72 hours and Mental Hygiene. is marked other than "natural; sumatic event, the Medical Exa To Be Completed by	(Specify only higha	t's Education st grada complated)	16a.	Decedant's Usua (Giva kind of wor life. DO NOT us	k don	a during most of	of work	ing	16b. Kind of B	usinass/Ind	lustry	
thar than	Elementery/Secondery (0-12)	Coilaga (1-4or 5+)		Engir	ieei	r			Avi	ation		
Hyge the C	17. Fathar's Nama (First, Middla,	Last)					s Nam	e (First, Middle, I	Aaiden Sumar	na)		
Mental H Mental H Merked ott atic ever	John Gedde	es Steele				Ida	ı Ge	neva App	legate			
permit. Pages 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exp ance. To Be Completed by	19a. informant's Name/Ralations Charles T. Cap							al Routa Number	-		Coda) and 21601	
1 and Health mm 27 ther tr	20a. Mathod of Disposition		20b Piace of	Disposition (Nam	a of				20c. Location			
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Departit. Departit Importuany inju	21. Signature of Funaral Sarvice	Licansaa		Thomas	Fu		Hom	e, P.A.			01610	
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Physician	700 Locust Street Cambridge, Marylan 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.											
/Medicai	immediata Causa (Finel	Vond	vical	To	-1	. C	6	1			16000	
Examiner	disease or condition rasulting in daath)	a. / C//V	1,00,7	v- 10	Ch	Como	7				How	
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The law requires that the death certificate be sate has been signed by the attending physicial, page 2 should be detached for use as the but Completed by Physician/Medical								24a. Was e perfor		av.	ara autopsy findings ailabla prior to mpletion of cause daeth?	
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	27. Manner of Death	28a. Date of Injury	28b. T	ime of 2	8c. Inj		on g	28d. Dascribe h			,,	
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tal or Attending P rs after death. st Director: After ti led in by the funera Certification:	3 Suicide 6 Could 4 Homicide determ	not be	- At homa, fa Specify)	m, street, factory	, offic	0		28f. Location (S City or Town	treet and Num n, Steta)	ber or Rura	I Routa Number,	
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (ng Physician: To the best of m Examiner: On the basis of ax and manner states	amination and									
outh on pl	29b. Signatura and titla of certifia			290	. Lice	nse number	,	2	9d. Date sign	ed (Month,	Dey, Year)	
- S - Ö	> Rock	& Bushe			0	4281	6		7/9/	21		
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Registrar	JUL 1	4 1999		N. P.	100	w						

Baltimore, Maryland 21215-0020 ${\mathscr M}$

Division of Vital Records, P.O. Box 68760,

Austin Steel



DHMH 16 Rav 6/95

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					Certificat	e of	Death			Reg. No.	- 1-	9.018	
	_	1. Decedent's Name (First, Middle, La	st)					1	2. Dete of Dea	ıth	Veer	3. Time of I	Death
Physician		WILLIAM SCH	KEVITZ						Month July	Dey 15	Year 1999	9:30	A.M
/Medica Examine	_	4a Facility Neme (If not institution, gh	re street and number)				4b. City, To	wn, or Loc	ation of Death	4c. County			
,		VAMHCS FORT HOW	ARD DIVISIO	N			FORT	HOWAI	RD	BALTI	MORE		
Funeral Director		5. Social Security Number 6. S		(In yrs. last birt	hday) If Unde Months	Deys		24 Hrs. Min.	8. Date of Birt (Month, Day 03-08-			olece (State or olry) SMTTH	
D >	-	Usual Residence of Decedenf 10a, Sfate 10b, County		10c. City, Town	or Location						1	0d. Inside Cit	v I imife
e Menyla Se-f abov		MD Prince G		Laurel								1X Yes	
th with the 23a or 2	Funeral Director	9010 Briarcroft	Lane		10f. Zi	Code 2	0708			10g. Citizen of V USA	Vhet Cour	nfry?	
L'a	P S	11. Marifel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1		13. Wes Dece If Yes, spe				ify Yes or No- lican, etc.)	Bled	a - Americ k, White, White		
d within 72 hours af giene. If then "neturel", or the Wed cal Exam	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondery (0-12)			Decedent's Usu (Give kind of we life. DO NOT u	ork done	durina mos	t of working	g	16b. Kind of Bu	usiness/în	duetry	
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Dearmit. Peges 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition 1X Burial 2 Cremation 3		cemeter	Disposition (Nerv., crematory or	other pl			Date -18-99	20c. Location -			
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permit. Pege Department of Important: If any Injury or price.		Afilhan K.	Laudue			van	t Fune		Home, I	nc.			
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cate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	D. D	oue to (or es e	consequence of)	*							
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To the To the comple		29b. Signature and title of certifier	and manner state)/,	1 29	CLicer	nse number	50		29d. Dafe signe	d (Month,	Dey, Year)	
		Turna	C. Ca	u, m.	V.	1/	4-1-	0		July 15,	199	9	
		30. Neme end address of person who	completed cause of de	eth (Item 23e)	(Type, Print)							,	
		AURORA C. TAN.	M.D. 9600	NORTH I	POINT RO	DAD,	FORT	HOWA	RD, MD	21052			
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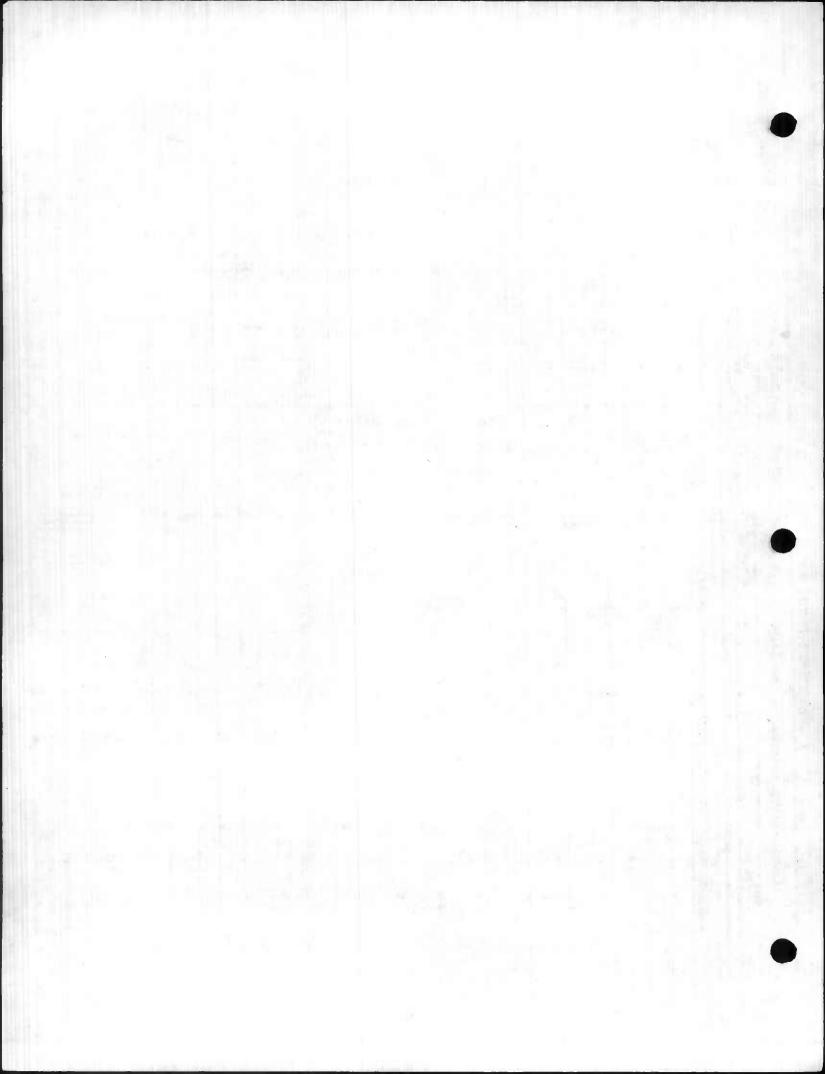
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Physician	Decedent's Name (First, Middle, Las	#) Helen Hum	mer Thada	n		2. Date of Deat Month	Day	Year	3. Time of Death
/Medical	4a Facility Name (If not institution, give		mer made		lb. City, Town, or Le	July 8,	1999 4c. County o	of Death	11:00 AM
Examiner	Suburban Ho				Bethesd		Montg		
Funeral Director	5. Social Security Number 6. Social Security Number 219-48-3964		In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, September	Year)	9. Birthplac	e (State or Foreign ngton, D.
P. A.	Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or Lo	cation				10d.	Inside City Limits
to the	Maryland Montgor	merv	Silver S	nring					1 ☐ Yes 2 🗓 No
or 28-4 be nout.	10e. Street and Number	ile Ly	DIIVCI D	10f. Zip Code		1	Og. Citizen of Wi	hat Country	?
23a c	15301 Beaverbroo	ok Court		20906	5	100	United	States	5
within 72 hours after death with the Maryland ens. Then "returel", or flems 23e or 28e-f show the Madical Examiner must be notified at the Madical Examiner must be notified at propleted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 N Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	11	Vas Decedent of H I Yes, specify Cuba □ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- American , White, etc White	112
22 should be filed within 72 ho And Mental Hygiens. 7 is marked other then "naturn traumetic avent, the Medical TO Be Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done OO NOT use retired maker	durina most of work	ing	16b. Kind of Bus		try
a other	17. Father's Name (First, Middle, Last)				18. Mother's Nem	e (First, Middle, I			
Menta Menta ricad rica To B	Lewis Irvin H	ummer			Alice	Virginia	Dove		
and h	19a. Informant's Name/Relationship (7		19b. Meilin	g Address (Street	and Number or Rus	al Route Number	, City or Town, S	State, Zip Co	ode)
end nazi	Michael Edward				North, R				20854
permit. Pages 1 and 2 should be Department of Health and Menta Important; 11 Nem 27 is marked eny injury or other traumede as pines. TO E	20a. Method of Disposition 1 🗓 Burial 2 Cremetion 3 C 4 Donation 5 Other (Speath)	Removel from State	20b. Place of Disposer cometery, crem Rock Cree	natory or other plea	July 17	1999	20c. Location - C Washingt		
Departi Depart Import eny in	1. Signature of Service	-	Ro	Neme end Addre bert A. Pu O West Mon	ss of Fecility Tiphrey Fund tgomery Ave	eral Home/ enue, Rock	Rockville ville, Ma	, Inc.	20850-280
Physician /Medical Examiner	23a. Part1. Enter the disease, or complete shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a	0	osis				0	terval Between nset and Death
cate be executed physician and the burlei-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	e to (or as e conseq	uence of):			1.3		
	Cause (Disease or injury that initiated events resulting in death) Last	c	e to (or as a consequ	uence of):					
d for i	Part II. Other significant conditions co	notributing to death but r	not resulting in the ur	nderiving cause giv	en in Pert I	23b. Did to	hacco usa con	tribute to th	e cause of death
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The lew requires had been a sage 2 should completed						24a. Was a perform	med?	avaita comp of dea	autopsy findings able prior to letion of cause ath?
Physician: The rule certificate oral director, page 1: To Be Co	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or	16)		
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be or Attending Physics after death. al Director: After this led in by the funeral of Certification: To	27. Manger of Death 12. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				y at k? Yes 2 □ No	28d. Describe h			
pital or Ati our after d eral Direct filled in by	4 Homicide determined	building, etc. (no doto and no	28f. Location (S) City or Town	n, State)		
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To the Hospital of Within 24 hours at To the Funeral DI completely filled if Medical Cer	29b. Signature and title of certifier	relais)	29c. Licens	e number 42 8	518 2	9d. Date-signed	(Month, Da	y, Year) 3, 199.
17	30. Hame and address of person who o	completed cause of deat	th (Item 23a) (Type,	9"Rock	ville 1	I tel &	1601	RIE	rost
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	100 11	,				

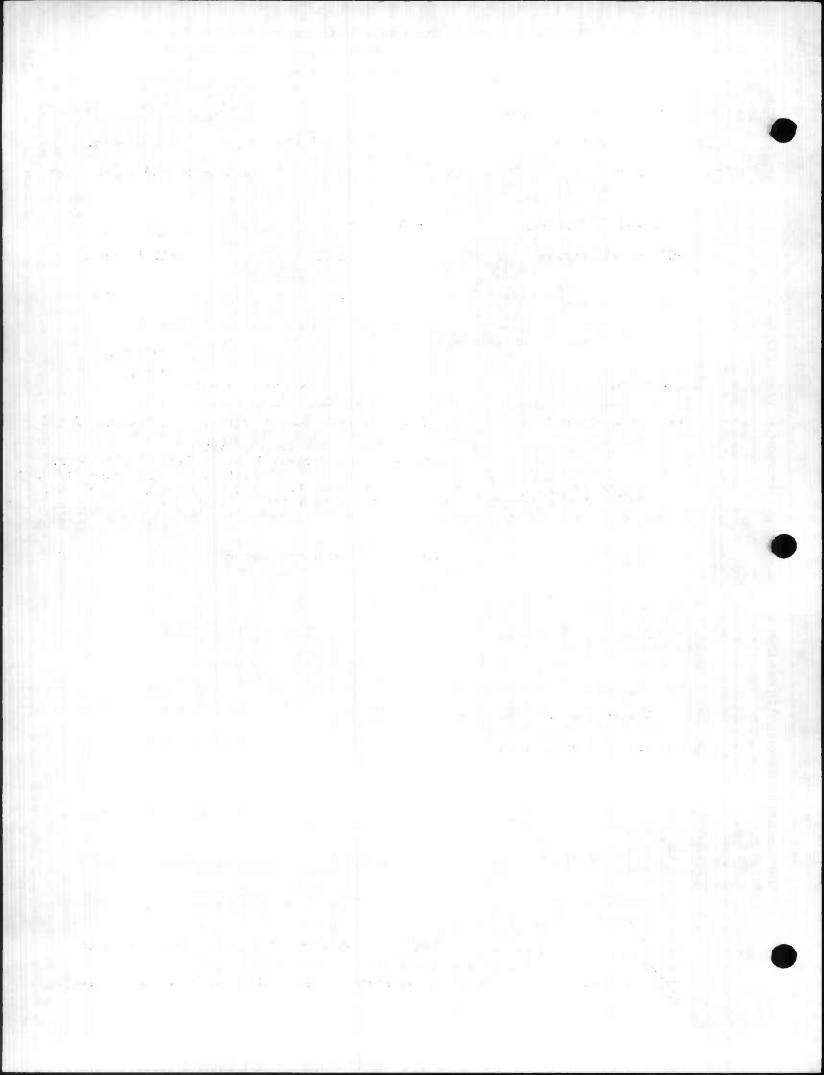
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State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	Mary W.	Tyson					July 1			:15 PM
Examiner	4a Facility Nama (If not institution, give					4b. City, Town, or L				
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de de de	(Specify only highest gra	da completed)		(Give kind of v	ork done	pation during most of work d)	ring			
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and selth	Preston A. Tyson/	Son	Ρ.	O. Box	281,	Harpers	Ferry,	West Vi	rginia :	25425
or the second	20a. Method of Disposition		20b. Plece o	of Disposition (N	ome of other ple	ce) July 1/3	Date	20c. Location -	City or Town, S	Stata
ballimore, semit. Pages 1 ar Separtment of Hee mportant: If them in y lojury or othe one.	1 Burlal 2 Cremetion 3 4 Donetion 5 Other (Specific		Monto	omery C	remat	orium, In		Bethesd	a Mary	land
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or Attending after death. Director: After Jin by the fune	3 Suicida 6 Could not be determined	28e. Plece of Inj building, et	ury - At home, f	erm, street, fect	ry, office		28f. Location (: City or Tox	Street and Numl vn, Stete)	ber or Rural Rou	ite Number,
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outh on the	29b. Signeture end title of pertifier	////		2		sa number		29d. Deta signe	d (Month, Dey,	Year)
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	30. Neme and address of person who									
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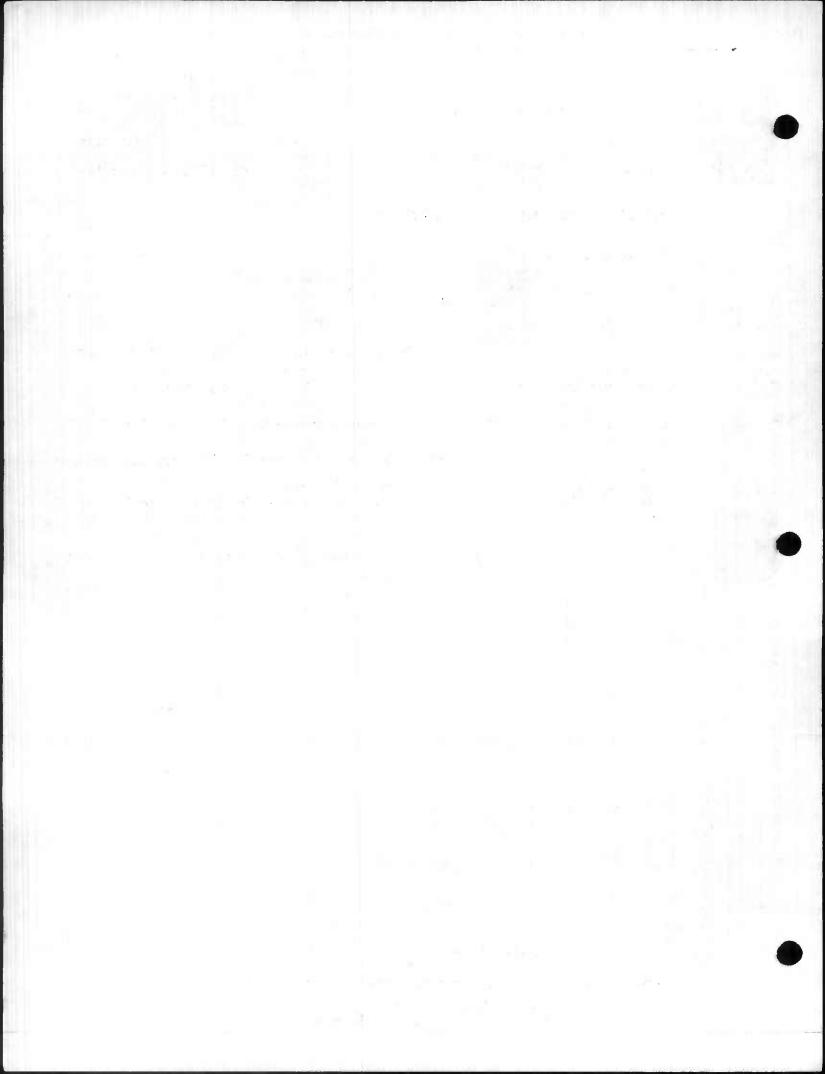


State of Maryland / Department of Health and Mental Hygiene

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23a Paight Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Individual Examiner	Page ment o tant: If i		4 □ Donation 5 □ Othar (Spacify)	Mar				7/16/99	Hurloc	k, Ma	ryland
Physician Medical Exeminer Physician Medical Exeminer	Depart Import sny in		21. Signature of Funaral Sanna Licanse	Э		Thomas F	uneral Hon		so Mar	wland	21612
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25. Was case are farred to medical axaminer? 1	m	, E						1 🗆 Y	as 2XXNo	1 🗆]Yas 2□ No
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Duilding, atc. (Spacify) 29a. Cartifiar (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Yaar) 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Mary Ann D. Moore, M. D. 2 Aurora Street Cambridge, Maryland 21613 31. Data filed (Month, Day, Year) 32. Registrar's Signatura	ding f th. After s funer	tlon	1 Natural 5 Panding	(Month, Day Year)				28d. Dascribe h	ow injury occurr	ed	
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30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Mary Ann D. Moore, M.D. 2 Aurora Street Cambridge, Maryland 21613 31. Data filed (Month, Day, Year) 32. Registrar's Signatura	Hospital 24 hours Funeral etely filled		(Check only 2 Medical Examine	er: On the basis of axamir	nowladga, daa nation and/or l	ath occurrad at tha invastigation, in m	tima, data and placa, y opinion, daath occur	and dua to tha d red at tha tima, d	eausa(s) and ma data and place, a	nnar as st	ated. tha cause(s)
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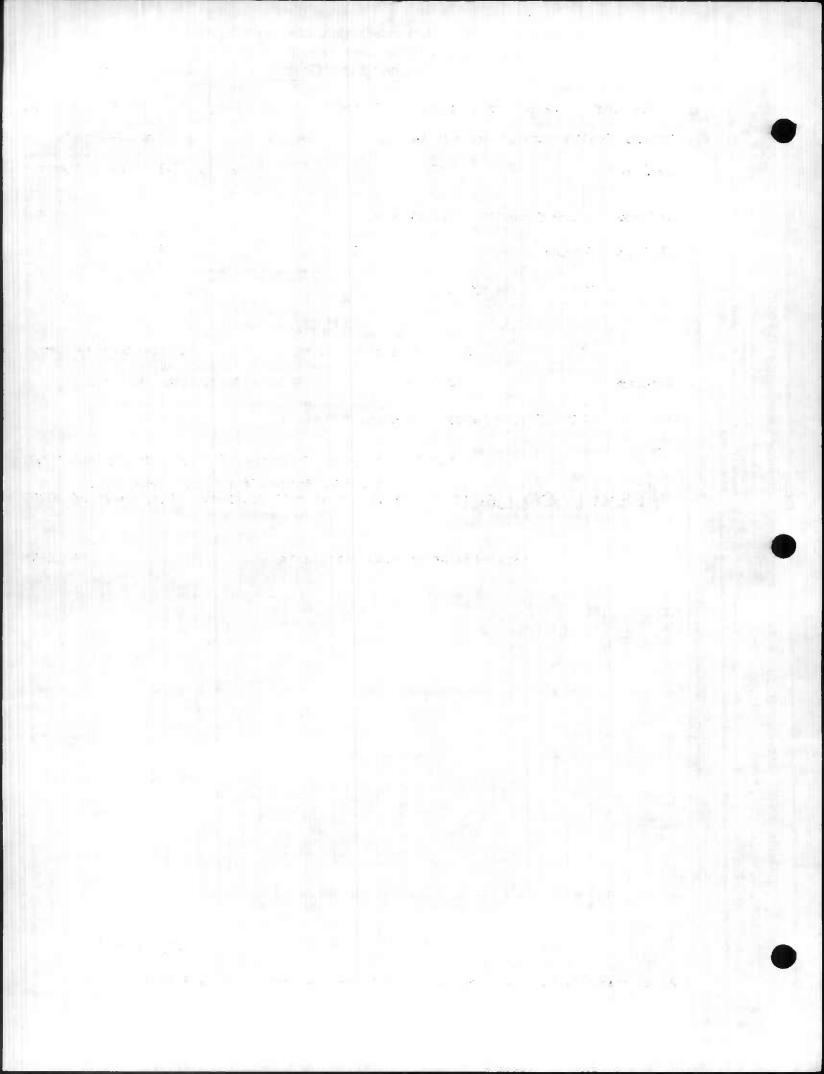
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

					y	Cert	ificate o	f Death	,	Reg. No.		123		
	Physicia	an	1. Decedent's Name (First, Middle, Las	t)					2. Dete of De Month	eth Dey	Year	a of Deeth		
	/Medic			one Rose	nthal	L	Uphof		July			:05A.		
	' Examin	er	4e Facility Neme (If not institution, give Mariner Health Ca		ater I	Laure1	L	4b. City, Town, or Laurel	Location of Deet	,	of Death e George'	s		
	Funeral Director		5. Social Security Number 6. Se 11	9x 7. Age □ M 2 X F	e (In yrs. last 78	birthday) Yrs.	If Under 1 Yes		8. Dete of Bir May 8,	th 1921	9. Birthplece (Stell Country) Orrana, Neb	te or Foreign raska		
Т	D .		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, To	own or Loc	ation				10d Inelds	City Limits		
	e Maryle la-f ahor	ctor		George's		svill						as 2 X No		
	th with th	al Director	10e. Street and Number 11611 35th Avenue				10f. Zip Code 2070			United	Whet Country? States			
020	172 hours efter deeth with the Maryland "natural", or frema 23a or 28a-f ahow edical Examinar must be mothled at	by Funeral	11. Meritei Stetus 1 Never Merried 2 Norried 3 Widowed 4 Divorced	12. Wes Decedent I Armed Forces? 1 Yes XXXII If Yes, Give Year or Dates:			Yes, specify C	f Hispanic Origin? (Suban, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	14. Rec Bied Specify	e - American Indien ck, White, etc. White			
5-0	72 ho	pted	15. Decedent's Edi (Specify only highest grad		1	6e. Decede	ent's Usuel Occ	cupetion ne during most of wo	rkina	16b. Kind of Bu	usiness/Industry			
21215-0020	within ene.	Completed	Elementery/Secondery (0-12)	College (1-4or 5	i+)		rch Ana	ne during most of wo ired) 11yst		National Security Agency				
and	S S S S	o Be C	17. Fether's Neme (First, Middle, Last) Abraham		Rosen	thal					ohansen			
Manyland	d 2 sh th and th am traum	F	The state of the s	, , ,					urel Route Numb	er, City or Town,	Stete, Zip Code)			
altimore,	Peges 1 and nent of Heelth int: If Item 27 iry or other tr	17. Fether's Neme (First, Middle, Last) Abraham Rosenthal 19a. Informent's Neme/Reletionship (Type, Print) James Harold Uphoff (Husband) 20a. Method of Disposition 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, cremetory or other placa) 20c. Method of Disposition 20c. Dete									City or Town, Stete			
Baltin	permit. Pege Department of Important: If any Injury or once.		21. Sign fix e of Funere Service Licans		Mary	22. Do	Neme end Ado	ress of Fecility Borgware	dt Funer	al Home	, P.A.			
_			23e. Pert1. Enter the disease, or comp shock, or heart failure. List only of	adman	lt.			er Mill R			Maryland Approxim			
<u>.</u>	Physician /Medical Examiner		Immediete Cause (Finel	. Carcinor		ry wi	th_meta					20 95		
	cuted nd ransit	Examiner	Sequentially list conditions.	b	Due to (or es	a consequ	uence of):							
ó,	e exe	I Ex	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	0										
x 68760,	entificate be executed ding physician and se as the burial-transit	/Medicai	that initiated events resulting in death) Lest	d	Due to (or es	a consequ	enca of):							
Вох	death cert e attending od for use	clan												
P.O.	thet the de led by the a detached	Physician/M	Pert II. Other significant conditions co	ntributing to death b	ut not resultin	ng in the un	deriying cause	given in Pert I.			antribute to the causes 3 ☐ Probably 4			
Records,	8 5 8	Completed by								en eutopsy ormed?	24b. Wera autop eveilable pri completion of death?	ior to		
	The law ate has b page 2 s	mo.							10	Yes ZOXNo	1 ☐ Yes 2	2 X [X]0		
Viita	delan: The	Be	25. Was case referred to medical examiner?						ath (Check only	one)				
0	Physician: this certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 ☐ inpatie			3LI DOA		lome 5 Res					
	ing After fune	Certification:	27. Menner of Death 1 🖾 Neturel 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		y Year)	b. Time of fnjury	M 1	njury at Vork? □ Yes 2 □ No		how injury occur		humbar		
=	ttal or Attendurs after deeth	Certif	4 Homicide determined	28e. Plece of Inju- building, etc	ury - At home c. (Specify)	a, tarm, stre	et, tectory, offi	De	281. Location (City or To		ber or Rural Route N	rumo o r,		
	To the Hospital or I within 24 hours after To the Funeral Director Completely filled in L	edical	29a. Certifier XX Certifying Phyone) 2 Medical Exam	yelclan: To the best of liner: On the bests of end menner ste	exemination	dge, death end/or inve	occurred et the estigetion, in m	time, dete end plec y opinion, deeth occ	e, end due to the urred et the time,	cause(s) and me dete end pleca,	anner as stated. and due to the ceur	se(s)		
	Tot Y com	X	29b. Signeture end title of cartifler	Den	۰			anse number .3668		July 9,	nd (Month, Day, Yea 1999	7)		
,	,-	ļ	30. Name end eddress of person who of					ogo Dawle	Mawritan	A 20740	y Yar			
•	Sta	te	Azher Hussain, M. 31. Dete fiied (Month, Dey, Year)		er's Signeture			eye raik,	HaryTal	id 20/40				



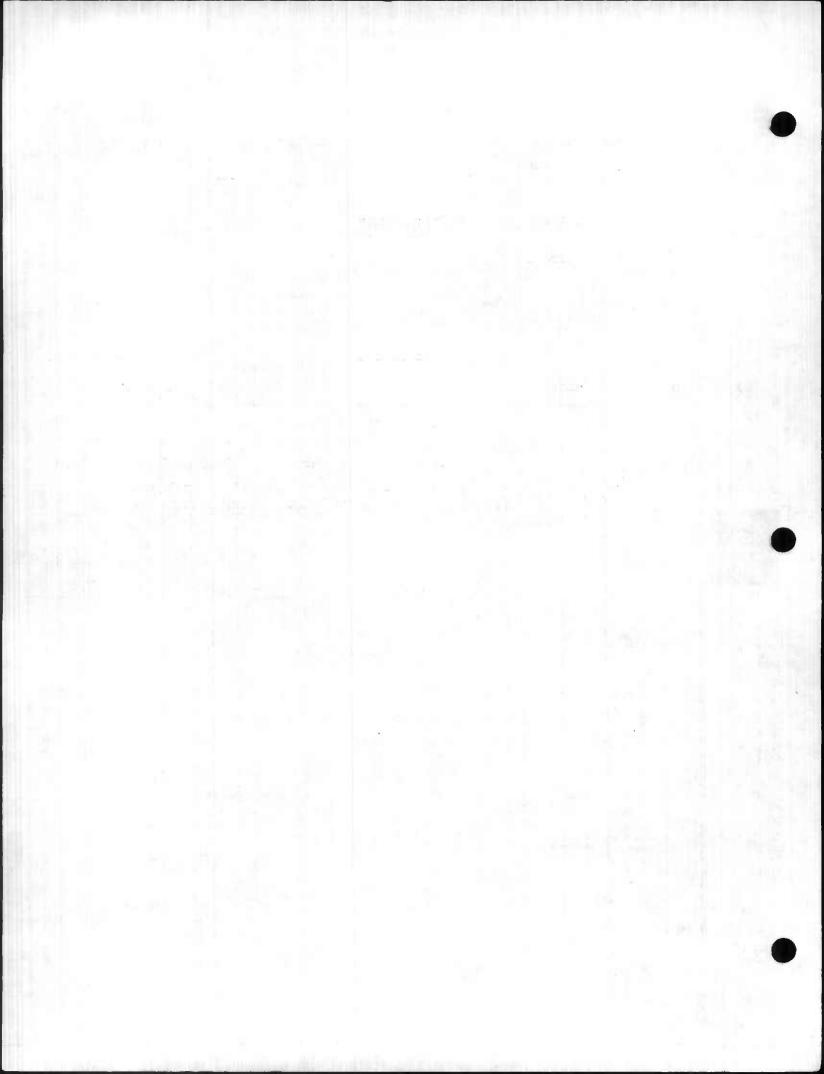
	State of Maryland / Department of Health and I Certificate of Death	Mental Hygien	
Physician /Medical	1. Decedent's Name (First, Middle, Last) ALICIA V. VASS	2. Date of Death Month D	Dey Year (0:40 A
Examiner Funeral Director	4a Facility Name (If not institution, give street and number) 4b. City, Town, or II Compared to the property of the property	een mo	Ac. County of Death ARFORD 9. Birthplaca (State or Foreign Country) MARJUM
Maryland Harbow Red at tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location HALFORD ABBLOEST		10d. Inside City Limits 1 Yas 2 No
Offer death with the Marylar fler death with the Marylar flerns 23a or 28-f show the mother of the mother of the mother of the mother of the flerner of the mother of the	10e. Streef and Number 10f. Zip Code 2/00/	10g. C	Citizen of What Country?
urs at ur	If Yes, Give 1 ☐ Yes 2 € No Specify: Yeer or Detes:	pecify Yes or No- o Rican, etc.)	14. Rece - American Indian, Black, White, etc. Specify: BLACK
	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) SEAM STRESS	king 16b.	Kind of Business/industry
re, Maryland 212 1 and 2 should be filed within 1 Health and Mantal Hygiene. 1 marked other than other traumatic avent, the M To Be Comp	17. Father's Neme (First, Middle, Last) 18. Mother's Nan	ne (First, Middle, Maide WOL TO	
e, Mary and 2 sho Health and 1 am 27 is menther traums	19a. Informant's Neme/Relationship (Type, Print) WILLIAM VA35 III 19b. Mailing Address (Street and Number or Ru WILLIAM VA35 III		
0 00- 2	20a. Method of Disposition Surial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. CALMEL CEMETERY	Date 20c.	Location - City or Town, Stata
Baltim permit. Peg Department Important: any Injury onnes.	21. Signature of Funeral Service Licensee 22. Name en Address of Facility BILL NERAL 553 LEWIS 37. H	HOME	
deeth certificate be executed deeth certificate be executed to the extending physician and address the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting is death). Let	liovase lisease hypert	onset and Deeth Lisease ension
P.O. day the day the detach	Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Atual Augustian	23b. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
ecord w requir s been s 2 should		24a. Was an au performed?	topsy 24b. Wera autopsy tindings available prior to completion of cause of death?
Vital Rec	axaminer/	1 ☐ Yes	2 No 1 Yas 2 No
Division of Vital Re To the Heapttal or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	1 Yes 2 No	oma 5 Presidence 28d. Describe how in 28f. Location (Street City or Town, Ste	jury occurred and Number or Rural Route Number,
ne Hospital n 24 hours in Funeral pletely filled	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and menner steted.	, and due to the cause irred at the time, date a	(s) and manner as stated. and place, and dua to the cause(s)
To the within To the comple	29b. Signature and title of certifier Douglas Clarkomp D314	76 7	Dete signed (Month, Day, Year)
_ 5	30 (Name and address of person who completed cause of death (Rem 23a) (Type, Print) 7505 OSLER DR, SUITEZIY, TOWSO	n/mo	21204
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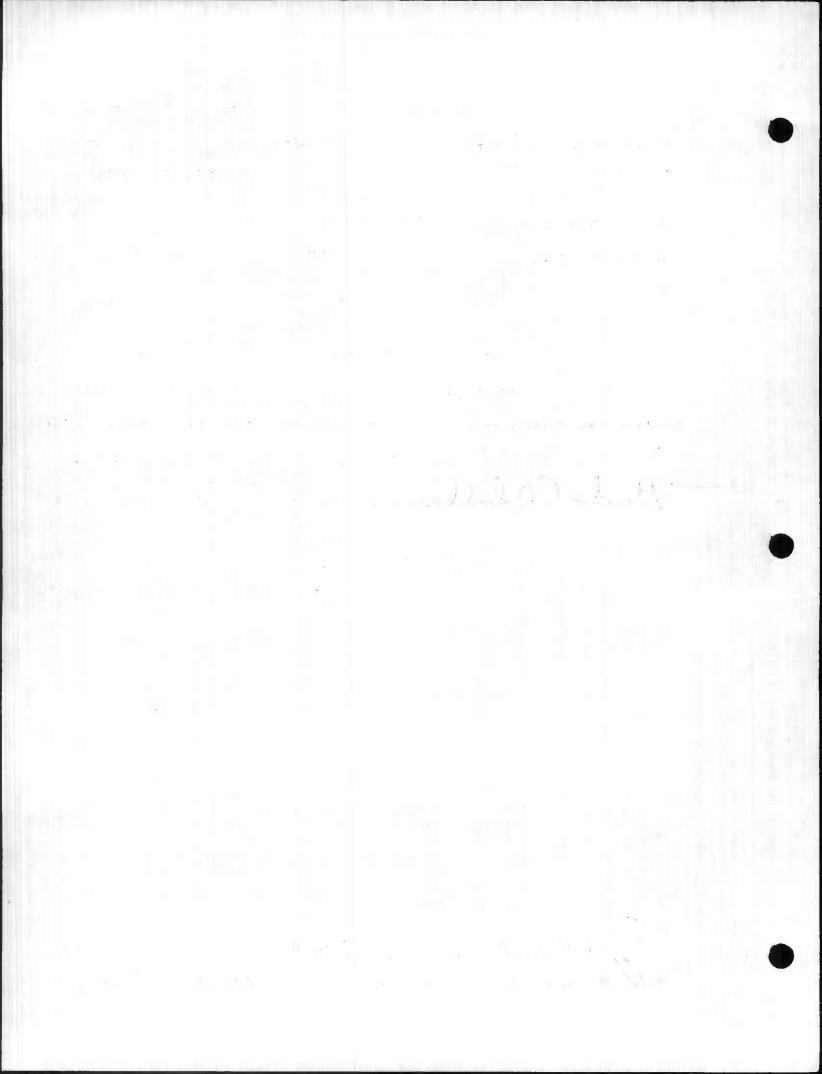
State of Maryland / Department of Health and Mental Hygiene

				7,0,0	ir y round /		rtificate of		wortan 17	Rea. No.		
			1. Decedent's Name (First, Middle, Last)						2. Date of D	eath		3. Time of Death
8	Physicia	_	IRVING	,	WEISS				July	9. 19	999	12:45 AM
1	/Medica	_	4a Facility Name (If not institution, give stre					4b. City, Town, or			County of Death	12:43 AM
	Examine	er	1001 Spring Street					011-			0.50	
_			5. Social Security Number 6. Sex		(In yrs. lasi t	hiethelevel		Silver Sp	oring		ontgomer	
	Funeral		127%	2 🗆 F		Yrs.	Months Days		(Month, D			place (State or Foreign ntry)
	Director		215-44-3223 Usual Residence of Decedent		86				Oct.25	191	12 Hung	ary
	B	- 1-	10a. State 10b. County		10c. City, To	wn or Lo	ocation				1	Od. Inside City Limits
	de la	5	Maryland Montgomery	_	041							1XXYes 2□No
	9 9 N	Q L	Maryland Montgomery	/	Silve	r Sp				40- 0%		4.0
	hours after death with the Maryland lurel', or flems 23s or 28s-f show Exerciser must be notified at	ᡖ					10f. Zip Code			10g. CRIZ	en of What Cour	nry?
	E23	Funeral	1001 Spring Street			,	2091			Unite	ed State	s
	6 6	5	11. Marital Status	Was Decedent E Armed Forces?	ver in U,S.	13.	Wea Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No Rican, etc.)	0- 1	 Race - Americ Black, White, 	
20	8		1 Never Merried 2 Merried	1 ☐ Yes 2X N If Yea, Give	0		1 Yes 2 No	Specify:			Specify: T.TL-1	
21215-0020	n 72 hours "netturel",	dby	3€ Widowed 4 Divorced	Year or Detes:							Whi	te .
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72	d within piene. r then	2		College (1-4or 5-	r)	life.	DO NOT use retire	od)				
	Hygier th	3		5+	St	tati	stician				eral Gov	ernment
Pu		Be	17. Father'a Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle	e, Maiden S	Sumame)	
ia i	Ment Se of the s	2	Joseph Weiss					Bertha		Sch	nwartz	
Maryland	D E E		19a. Informant's Neme/Relationship (Type,	Print)	19	b. Meili	ng Address (Street	t and Number or Au	ıral Route Numl	ber, City or	Town, State, Zip	Code)
	Health Health em 27 i		David Weiss / Son		8	05 I	Caggert D	r. Belle	Mead, N	J 085	502	
ore	0 7 E 0		20a. Method of Disposition		20b. Piace	of Dispo	osition (Name of matory or other pla	(ca)	Date	20c. Loc	cation - City or To	wn, State
Baitimore,	2 2 4 5 2		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	ovel from Stete			non Ceme		July	Adol	lphi, Ma	weel and
aiti	Department Properties Important: any Injury and and and and and and and and and and		21. Signa of The manager	11		2	2. Neme and Addre	ess of Facility				Lyrand
ă	Ped Aug	1	VIIII	15	//			rew Memor				
7	_	-	22a Parti Fater the diseases	Suf	the death D	2	32 Carro	11 St. NW	Washin	gton,	DC 200	
1			23a. Pert1. Enter the disease, of complete shock, or heart feilure. List only one of	au each lin	Sile Gestil. Do	J HOL BIII	ter the mode of dyr	rig, such as cerolat	or respiratory i	milest,	1	Approximate Interval Between Onset and Death
44	hysician /Medical		Immediate Cause (Final	/	and	1-0	nuli		n	~ ~~	1	in d
	Examiner		disease or condition resulting in death)		unax	w	Fulle	onar	5 10	105		Tay.
		۱ ۵		PO	ue to (or es	a cons	wence of	10.00	JE	160	200	- ke
	g tig.	Examiner	b. —	- U	non	NC	- Inter	wales	0	Hur	50041	HUEN
	and and	X	Sequentially list conditions, if any, leading to immediate	00	ue to (or es	consec	quence of):	10	Donl	1 1	21/11	71000
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387	phy the	odicai	resulting in death) Last	PD.	oue to (or es a	consec	juerice of):	11. L. D	K D	. 010	· 2	SURO
×	v requires that the death centing been signed by the attending should be detached for use a	_	d	- CH	romi	0	72211	verne) wer	wind	00 05	SYRS.
Вох	ins law fequires that the death certate has been signed by the attendingage 2 should be detached for use	Completed by Physician/M									1	
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۵.	detay	5	When Comes	120164	estu	2	1 1200	200	115	Yes 2	□ No 3 □ Pro	bably 4 ☐ Unknown
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ec	N 28 W	2									of	death?
	pag	5							10	Yes at	100 1E	☐Yes 2☐ No
Vital	ctor,		25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	one)		
2	dire ce	0	1 Yes 2 No Hos	oital: 1 Inpatien	t 2 ER/C	Outpatier	nt 3 DOA Ot	her: 4 Nursing H	lome 5	idence 6	Other (Specif	על
0	2 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 -	=		28a. Dete of Injury (Month, Day	Year) 28b	Time o	f 28c. Inju Wo	χat	28d. Describe	how injury	occurred	
0	e for Africa		1/2 Netural 5 Pending 2 Accident investigation	(,,	,	прогу		Yes 2 □ No				
Division of	octo by th		3 Suicide 6 Could not be determined	28e. Piece of Inju	ry - At home,	ferm, st	reet, fectory, office			(Street and	Number or Rura	il Route Number,
ā .	D D D	Certification	4 1 1011000	building, etc.	(Specify)				City of 10	wii, State)		
	houn y fills		29a. Certifier 1 Certifying Physicia	n: To the best of	my knowledg	ge, deetl	h occurred at the ti	me, date and place	, end due to the	cause(s)	and manner as s	tated.
	or a negata of Attending Programs: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edicar	(Check only and Medical Examiner:	On the basis of and manner stat	examinetion a	ind/or in	vestigation, in my o	opinion, deeth occu	rred at the time	, date and	place, and due to	the cause(s)
4	Toth		29b. Signature and title of certifier	1. 1			29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
	1		- Meran	100			De	20m		-	116/06	/
	L	-	30. Name and address of person who comp	leted/kause of de	ath (Item 22=	ravila	Print) ^	1180.	•	- /	10/1	
		1	Shag SAID	ANTI	1596	13	SIIF	L 400	W/ I	rupa	209	10
	State	9	31. Date filed (Month, Day, Year)	32. Registre	's Signeture	,	1 - 1210	U. K			1	
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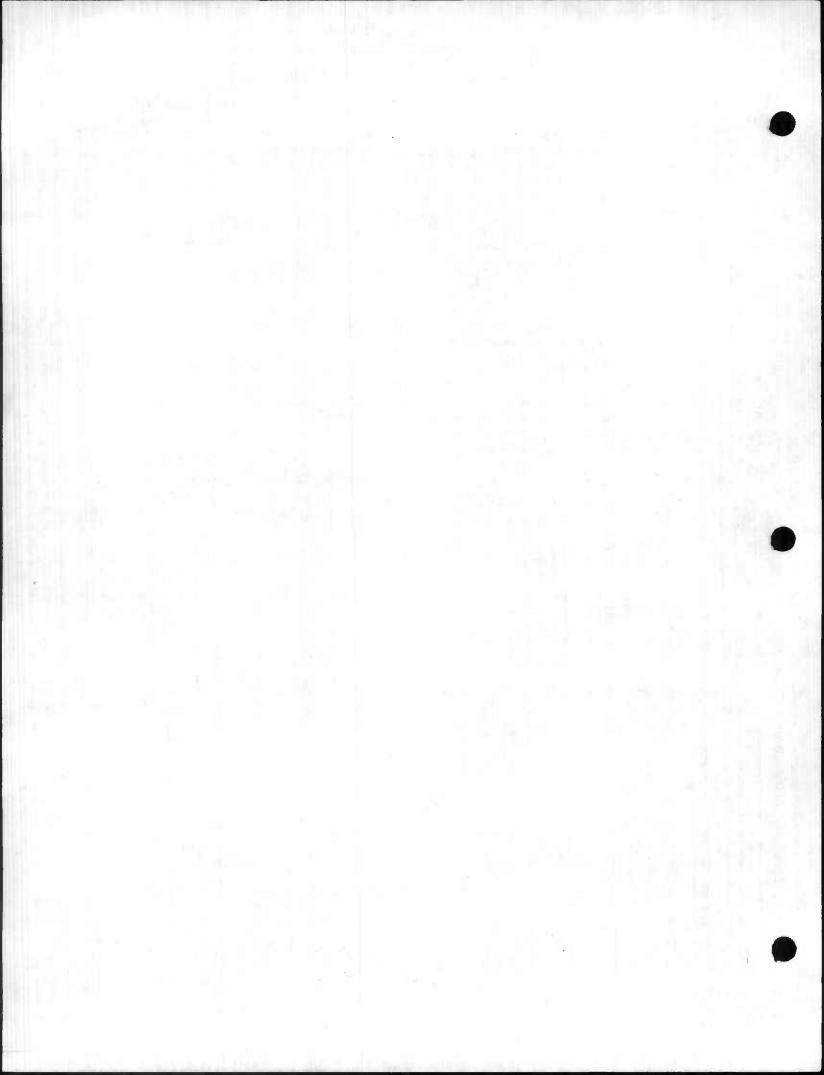
State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Re	g. No.	6.3	00.10	
Should be	1, Decedent's Neme (First, Middle, Last)				2. Dete of Death Month		Year ;	3. Time of Death	
Physician /Medical	Helen M.	Wernimont			July			5:30 PM	
Examiner	4e Facility Name (If not institution, give street an	d number)		4b. City, Town, or L	ocation of Death	4c. County of	ol Deeth		
Funeral Director	Wilson Health Care C 5. Social Security Number 6. Sex 376-12-0074	7. Age (In yrs. last birt	thday) If Under 1 Yeer Yrs. Months Deys		8. Dete of Birth (Month, Dey, March 8,	Year)	gomery 9. Birthpled Country Nebra	e (Stete or Foreign	
filled within 72 hours after death with the Maryland Hygiene. Hygiene, natural, or items 23a or 28a-f show not, the Medical Exacting rough be notified at a Completed by Funeral Director	Usuel Residence of Decedent 10e. Stete 10b. County	10c. City, Towr	or Location				104	. Inside City Limits	
f ahor			hersburg				100.	1⊠Yes 2□No	
9 58	Maryland Montgomery 10e. Street and Number	Gait	10f. Zip Code		10	g. Citizen of W	het Country	?	
D P	301 Russell Avenue		201	877		United	Stato		
F 22		Decedent Ever in U.S.	13. Was Decedent of If Yas, specify Cul				Race · American Indian,		
a, or terms 230 of 288-1 anow Examiner runt be notified at by Funeral Director	1⊠ Never Merried 2 Merried 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ed Forces? Yes 2⊠ No s, Give or Detes:	If Yes, specify Cul		Ricen, etc.)	Specify:	, White, etc Whi		
natural, adical Exc leted by	15. Decedent's Education		Decedent's Usuel Occu (Give kind of work done	pation	lian 1	6b. Kind of Bus	siness/Indus	stry	
or other traumatic event, the Medical To Order Traumatic event, the Medical To Be Completed	(Specify only highest grade completed in the complete Elementery/Secondary (0-12) College Col	oge (1-4or 5+)	life. DO NOT use retin	ed)	(III)		_		
F S	17. Father's Neme (First, Middle, Last)	5+	Professor		ne (First, Middle, M		lege		
s merked other than aumatic event, the Me To Be Compl				To. Mother's Neil	_				
To		ernimont			Roseani		Wils		
raun raun	19e. Informent's Neme/Reletionship (Type, Print		Melling Address (Stree						
other tra	Harold R. Lanman/Pers. 20e. Method of Disposition		1 Russell A Disposition (Name of	venue, #		thersbu Oc. Location - C			
Important: If item 27 any injury or other tr	1 ဩ Burial 2 ☐ Cremetion 3 ☐ Removel 1 4 ☐ Donetion 5 ☐ Other (Specify)	from Stete	y, cremetory or other place. Cemetery	17	7/13/99 G				
Important: If its any injury or of	21. Signature of Funeral Service Licornee	hel han	22. Name end Addi	. De	eVol Fune			20877	
ysician Medical	23a. Pert1. Enter the diseese, or complications is shock, or heart leiture. List only one cause Immediate Ceuse (Finel		not enter the mode of dy	ring, such as cardi e c	or respiretory arre	st,	A In	pproximate iterval Between enset end Deeth	
aminer 💆	disease or condition resulting in deeth) e	Due to (or es a c	consequence of):	8			5	weeks	
n and iel-transit Examiner	Sequentially list conditions, b. ——	Due to (or es e	consequenca of):	nevii J			-	weag	
cien a	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	11 po 50	ar coma				1	years	
ettending physicien and for use es the bunel-transit clan/Medical Examir	that Initiated events resulting In deeth) Lest	Due to (or es e c	consequence of):			1	1		
or us	- 4.								
etached for us Physician/	Pert II. Other significant conditions contributing	to death but not resulting in	the underlying cause g	iven In Pert I.				ne cause of death?	
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should should leted					24a. Wes er perform		availe	autopsy findings able prior to pletion of ceuse ath?	
page 2					1 ☐ Ye	s 2BTNo	1 🗆 Y	fes 2□ No	
± 5 €	25. Wes case referred to medical			26. Plece of Dee	th (Check only one)			
	examiner? 1 Yes 2 No Hospitel:	1 Inpatient 2 ER/Ou	tpatient 3 DOA	ther /	ome 5 Reside		r (Specify)		
\$2 E	27. Menner of Deeth 28a. I	Dete of Injury 28b. T	ime of 28c. Injury	ury at ork?	28d. Describe ho				
To the Funeral Director: After to completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be	Plece of Injury - At home, 1e outlding, etc. (Specify)		Yes 2 No	28f. Location (Str City or Town		er or Rural R	Route Number,	
To the Funeral D completely filled i Medical Ce	(Check only 2 Medical Examiner: On t	o the best of my knowledge the basis of examinetion end menner steted.							
To the	29b. Signeture enotitie of certifier		29c. Licer	nse number	29	d. Dete signed	(Month, De	y, Year)	
)	I John R Me	luch Mi	D DI	9294		July	9,19	99	
	30. Name and address of person who completed To How R. MELNICH		Type, Print) SELL AVE	GAITH	ensouna	Mol.	2087	9	
State	31. Dete liled (Month, Dey, Year)	32. Registrer's Signeture	4 local	/. /					

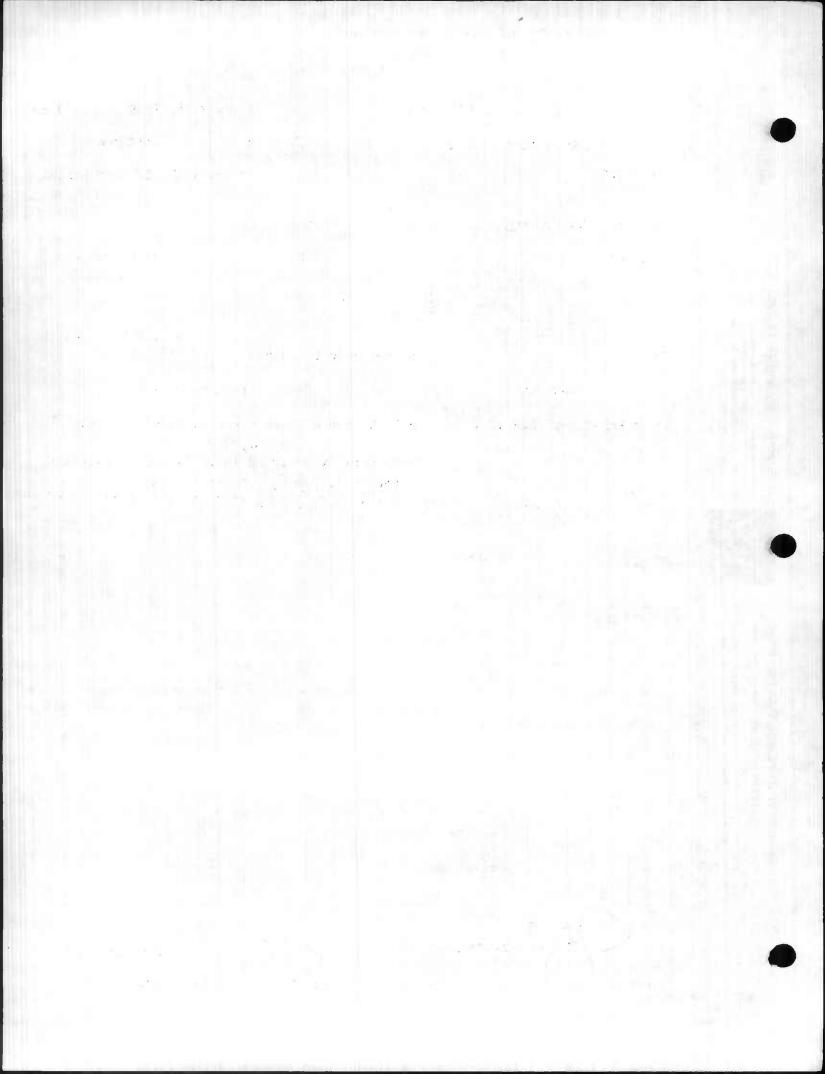


State of Maryland / Department of Health and Mental Hygiene

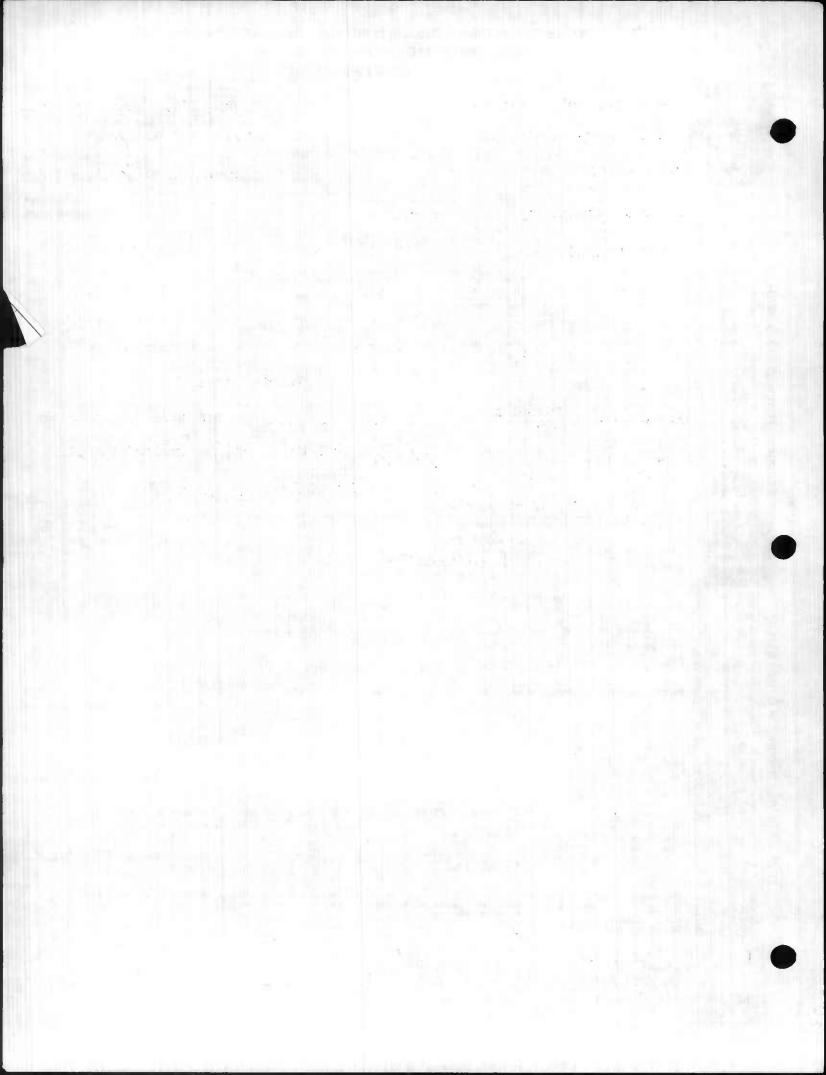
			State of Ivial		ertificate of			Reg. No.	2 4	0.011.7
P	hysician	1. Decedent's Nama (First, Middle, Las	()		2 1 - 2	2	2. Dete of De Month	Day	Year	3. Time of Death
	/Medical	Cleta							99	3:30P.
) E	xaminer	4a Facility Name (If not institution, give Fairland Adve	4b. City, Town, or L Silver			gome 1	сy			
	neral ector	5. Social Security Number 6. Security S	7. Aga (☐ M 2]X] F	(In yrs. last birthda) 105 Yrs.	Months Days		8. Data of Biri (Month, Da Sept. 1	y, Year) .9,1893	9. Birthplac Country Washi	a (Stata or Foreign ngton
Maryland	Tanow Tandari	10a. State 10b. County Maryland Howard	1	Oc. City, Town or Columbia					10d.	Inside City Limits
th with the	at be notified	10e. Street and Number 7505 Summer Bloss	som Lane		10f. Zip Code 2104	16		10g. Citizen of V United		
Id 21215-0020 filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or heme 23a or 28a-f ahow ent, the Maroldal Exerciper treast the hydraed at	Exemple mass	11. Marital Status 1 Never Merried 2 Merried 3 Nover Merried 4 Divorced	12. Was Decedent Ev Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detas:	er in U,S. 13	Was Decedent of I If Yes, specify Cub 1 Yes 2 No	Hispanic Orlgin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rac Blac Specify	e - Amarican k, White, atc. : Whit	
	d dwo	15. Decedent's Ed (Specify only highest grad Elementery/Secondery (0-12)	ucation de completed) Collega (1-4or 5+)	(Giv	edent's Usuel Occu re kind of work done DO NOT use retire	pation during most of work id)	ing	16b. Kind of Bu		iny
D H	metic event, To Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nem	e (First, Middle,			
Aarylan 2 should be f and Mental H	To E	Edward		Campbe1	.1	Evalina			Clevel	and
N Page	r train	19a. Informent's Neme/Reletionship (7) Bonnie Hope Beard			-	e as #10	al Route Numbe	er, City or Town,	State, Zip Co	ide)
Pages nent of		20a. Mathod of Disposition 1 Buriel 2 Toremetion 3 4 Donation 5 Other (Specify,	Removal from State		emetory or other ple	natory 7/1	Data 4/1999	20c. Location -		, Stata Virginia
Baitim permit. Pag Department	any injury or	21. Sign 1 re of Funeral Service Licente	ngward	t . :	22. Neme and Addre Donald V. 4400 Powd	Borgward	t Funer	al Home, sville,	P.A. Maryla	and 20705
Physi	ician	23a. Pant. Entar tha disaasa, or comp shock, or heert feilure. List only o	lication, that caused thene see on each line.	ne deeth. Do not e	nter the mode of dy	ing, such as cardiec	or respiretory a	rrest,	Int	oproximate terval Between nset and Death
	dical	Immediate Cause (Final disaase or condition		MYOCA	LDIAL	WARROT	100		A	CUTE
CXAII		resulting in deeth)	Du	ue to (or as a cons	equence of):				1	
68760, ficate be executed	prystrain and significant the burief-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Du	ue to (or as a cons	equence of):				1	
		resulting in death) Last	Du d.	a to (or as e conse	equence of):				1 6	-3.5
death cert	etached for use a Physician/M	Part II. Other significant conditions co	ntributing to death but r	not resulting in the	underlying cause gi	iven in Pert I.	23b. Dld	tobacco usa co	ntributa to th	e cause of death?
P.O.	be detached by Physic						10	L	-	oly 4 Unknown
Oro	should						24a. Was perfo	an autopsy rmed?	availa	autopsy findings ible prior to letion of cause ath?
The law	page 2						101	res 2)KNo	1 🗆 Y	'es 25 No
VITAI Iclan: Th	6 6	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)		
Of Vita Physician:	T di	1 ☐ Yes 2 No	Hospital: 1 Inpatient		ent 3LJ DOA	4		dence 6 Oth		
C 2 3	led in by the funer Certification:	27. Menner of Death 1 Naturel 5 Pending 2 Accident invastigation	28a. Dete of Injury (Month, Dey Y	(ear) 28b. Tima Injury	Wo	ryat uk?]Yes 2∐No	28d. Describe	how injury occur	red	
DIVISION of Attending a after death.	d in by t	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury building, etc. (/ - At home, ferm, t (Specify)	street, fectory, office		28f. Location (: City or To	Street and Numb vn, State)	er or Rural R	oute Number,
Hospital or Attend 124 hours after death Elineral Director	dical		sician: To the best of r iner: On the basis of ex and manner stete	caminetion and/or						
To the within	Me	29b. Signeture and title of certifier	1		29c. Licen	se number		29d. Dete signe	d (Month, Da	y. Year)
	0	I Mon a	lu-		DZ	4997		7/14	1/29	
- Ic		30. Name and address of person who co		th (Item 23a) (Type EMAY LA		unec i	nd 2	0707		
R	State egistrar	31. Date filed (Month, Dey, Year) JUL 1 6	32. Registrar's	s Signature	B. lo	a Val				



	1. Decedent's Nem	a (First Midd	lla. Lasti			Cel	uncale	of Deatl	/	2. Data of De	Reg. No.	_	3. Time of Death	
ician dical	1. Decedent's Nama (First, Middla, Last) James L. Williams								Month July	Day 11, 19		2;47 am		
niner	4a Facility Nama (If not institution	on, giva stre	et and numb	er)			4b. City, 7	fown, or L	ocation of Death	4c. Coun	ity of Death		
	10400 Overgate Place					1	tomac			ntgome	mery			
al	5. Social Security N	lumber	6. Sax		Aga (In yrs.	last birthday)	If Undar 1	Yaar If Unda Days Hours	ar 24 Hrs. Min.	8. Data of Birt (Month, Da	th v. Year)	9. Birthpl	ace (Stata or Fora	
r	044-30-2	003	1 <u>8</u> ÇI M	2□ F	61	Yrs.		.,,					ecticut	
	Usual Rasidance o	1												
	10a. Stata	10b. County	1		10c. Ci	ty, Town or Lo	cation					10	d. Inside City Lim	
Director	Maryland	Mor	ntgome	rv			P	otomac					1 □ Yas 2 🔀 !	
5	10e. Street and Nu						10f. Zip C				10g. Citizen o	f What Count	ny?	
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	1 Navar Marr	ied 2107 Mar		Armed Force			Yas, specify	Cuban, Maxic	an, Puarto	Rican, atc.)	BI	lack, Whita, e	etc.	
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ı		15. Decedar			· 19	62	lant's Usual (Decupation			16h Kind of	Business/Ind	hite	
İ	(Spec	city only highe	ist grada co	mplated)		(Giva	kind of work	dona durina me	ost of work	ing			Health	
ı	Elementery/Seco	ondary (0-12)		Collega (1-4d	or 5+)								пеатип	
	47 Cabada Nama	/Final Latelate	1 1	5+		Seni	or Buc	lget Ana		a (First, Middle,	Servi			
	17. Fathar's Nama	(First, Middle,	, Last)					18. Mot	nars Nam	a (FIFST, MIDDIE,	Malgan Suma	ama)		
imporant: if their 27 is marked other than institutal; or items 24s or 28s-1 and Injury or other traumatic event, the Medical Examines must be notified at pace. To Be Completed by Funeral Director		U	nknowi	1						Blanche	Willi.	ams		
-	19a. Informant's N	ame/Raiation:	ship <i>(Type</i> ,	Print)		19b. Maillr	g Address (S	Street and Num	ber or Au	al Routa Numbe	er, City or Tow	m, Stata, Zip	Code)	
-	Karen B	rletic-	-Willi	lams/	Wife	10400	Overs	ate Pla	ace P	otomac,	Maryl	and 20	854	
	20a. Method of Dis				20h I	Place of Disno	sition /Nama			Data	20c. Location			
1	1 Burial 2			oval from Sta	ta				-		D . 1.1	1. 27.	1 . 1	
	4 Donation		* **	7		Montg	omery	Cremat	orium	i Inc.	Bethes	da, Ma	ryland	
	21. Signatura of Fo	marai Sarvice	Licensaa	// .		Ŕ	bert	Pump	hrey	Funeral	Home/	***	sin Aven	
	XZ	m)	Lask	nt	M00	335 Be	thesd	a-Chevy	land	20814-3	1501	Wiscon	sin Aven	
er	Immediata Causa disaasa or condition resulting in deeth)	(Final on	Θ	Meta		c Blad		ncer					2 Years	
edicai Examiner	Sequentially list co	nditions,	b		Dua to (or as a conseq	uance of):							
ì	Sequantially list co if any, leading to in cause. Enter Unde Cause (Disease or	n <i>m</i> adiate	,									1		
3	that initiated avents rasulting in death)	5	c		Dua to (d	or as a consaq	uance of):							
	rasulting in death)	Last												
			d									<u> </u>		
5	Pod II Other elani	loant conditt	one contrib	sting to doubt	but not see	ulting in the cu	ded in a cou	an airen in Das	4.1	22h Did	tohenno use r	ontdbute to	the cause of dea	
riiysiciaiim	Part II. Other signif	ILEIN CONUM	UITS CONTRID	July to death	DULITOL FAS	outting in the UI	idanying cau	sa givan in Par	t 1.					
										10	Yes 2 No	3 Prob	ably 4 🗵 Unkn	
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			at I					26. Pla	ce of Deal	h (Check only o	one)			
	25. Was case refer	red to medica		ital: 1 🗆 Inn	atient 2	ER/Outnation	t 3 🗆 DOA	Other		oma 5 🕅 Resid		thar (Specific	,)	
3	25. Was case referexaminer? 1 ☐ Yes 2X		Hosp	I Inpatient 2 LEP/Outpatient 3 L DOA					coronig 110	28d. Dascribe			,	
3	examiner?	No		8a. Data of I	28a. Data of Injury (Month, Day Year) 28b. Tima of Injury at Work?									
	examiner? 1 ☐ Yes 2X 27. Mannar of Deat 1 X Natural	No h 5 ☐ Pandii	ng 2	8a. Data of I (Month,	Day Year)		M 1 Yes 2 No 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)				28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)			
To Be	examiner? 1 ☐ Yes 2 📉 27. Mannar of Deat	No h 5 ☐ Pandii	ng Igation	(Month,	Injury - At h	oma, farm, str fy)		office				mber or Rura	l Routa Number,	
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	Decedent's Name (First, Middle, Last)	ertificate of		2. Dete of Dea	eg. No.		3. Time of Death				
sician edical	Mary Elizabeth Williams		July	14, 199	5:00 A.M						
miner	4e Facility Name (If not institution, give street end number) Circle Manor Nursing Home		4b. City, Town, or Loc Kensingto		ry						
I	5. Sociel Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthde 90 Yrs.	Months Devs		8. Date of Birth (Month, Dey	Year) 22, 1908	9. Birthpl Count	ace (State or Foreign ry) inois				
	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or					10	d. Inside City Limits				
ctor	Maryland Montgomery Kensin	gton					Yes 2□No				
Dire	10e. Street and Number 10231 Carroll Place	20895	1	Og. Citizen of Wi United		•					
by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	3. Wes Decedent of H If Yes, specify Cubi	dispanic Origin? (Spec an, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race Bleck Specify:	America White, e	etc.				
ovent, in Medical Englishment, Be Completed by	(Specify only highest grade completed) (Gi	cedent's Usuel Occup ive kind of work done a. DO NOT use retired ecretary	oation during most of working d)	orking 16b. Kind of Business/In			ustry				
	17. Fether's Neme (First, Middle, Last) H. G. Williams	-	18. Mother's Neme Fannie	(First, Middle, Hunter	Maiden Surname						
Jury or other traumatic event, I			and Number or Rural								
	20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from State 4X Donetion 5 Other (Specify) 20b. Plece of Disposition Commercial ACTION A	sposition (Name of cremetory of other pla Sh. Univer Center	Sity	1 1/	20c. Location - 0 Washingt						
	21. Signature of Funerel Service Licensee Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037										
edical Examiner	Immediate Cause (Fine disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e constitutions) Due to (or es e constitution				7.00073						
Physician/M	d		In Book	23b. Did tobacco use contributs to the cause of deat							
-6	Pert II. Other significant conditions contributing to death but not resulting in the	e underlying ceuse gi	veri in Pett I.	1 Yes 2 No 3 Probably 4 Unknow							
7				CC			ore autopsy findings allebie prior to appletion of cause death?				
				24a. Was a perfor	an autopsy med?	of					
Completed by				24a. Was a perfor	med?	of	Yes 2□ No				
Be Completed by	25. Wes cese referred to medicel examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 FR/Outpa	tient 3□ DOA Ott	26. Place of Deeth	perfor	res 2 No	of (
To Be Completed by	examiner? 1	e of 28c. Inju	her: Nursing Hom ny et nk?] Yes 2 \(\sum No	perfor 1 Y (Check only or ne 5 Resid 8d. Describe h	res 2 No	of o	/)				
Certification: To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Dete of injury (Month, Dey Year) 28b. Tim. (Month, Dey Year) 28b. Plece of Injury - At home, farm, building, etc. (Specify)	e of Wo M 1 Street, factory, offica	her: The Nursing Hom ry et 2 rk? J Yes 2 No 2	perfor 1 Y (Check only or 1 Exercise	red? Yes 2 No ne) lence 8 Othe low Injury occurre Street end Number m, State)	of of 1 E	r) I Route Number,				
Certification: To Be Completed by	examiner? 1	e of y M 28c. Inju Wo 1 C street, factory, offica	her: Ap Nursing Hom ry et 2 rk? I Yes 2 No 2	(Check only one 5 Reside 8d. Describe has Control of the Control of the control o	res 2 No ne) lence 8 Othe low Injury occurre itreet and Number m, State)	of of 1 E	/) I Route Number,				
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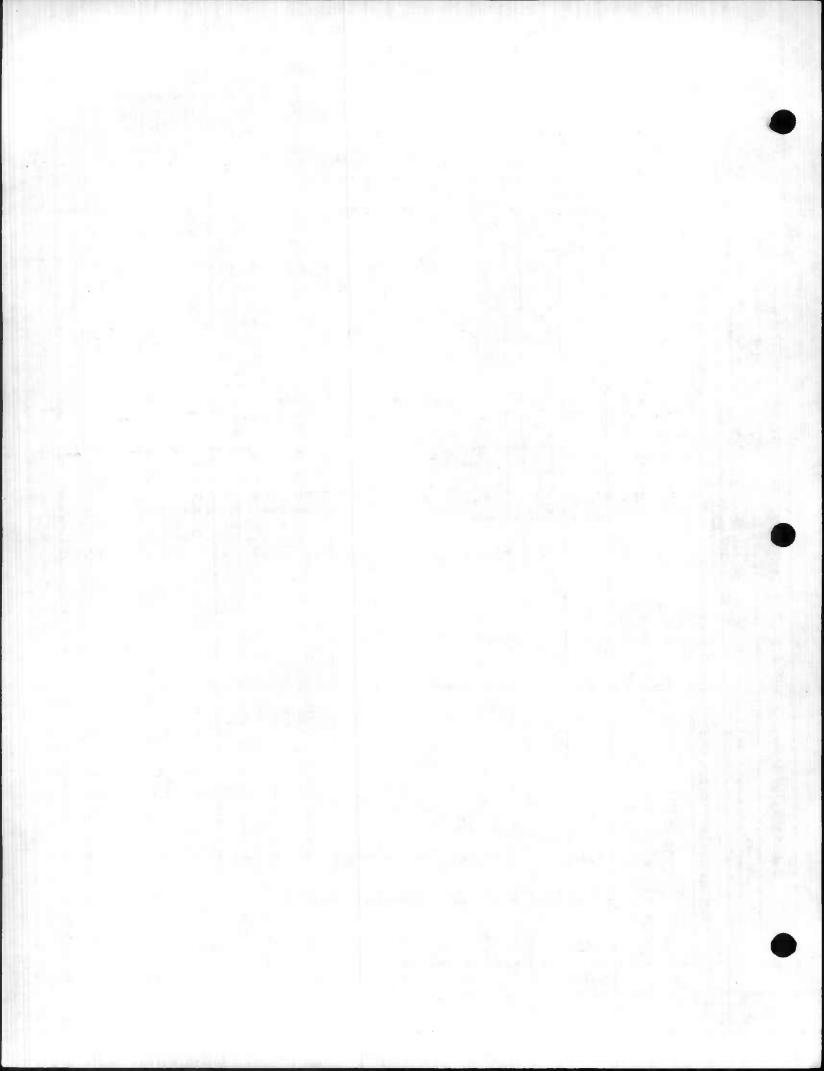
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month LY 7, **Physician** WILSON 1999 ANNIE MAE 1:55 AM /Medical 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brooke Grove Rehab & Nursing Ctr. Sandy Spring MONTGOMERY # Under 1 Year | # Under 24 Hrs. | 8. Data of Birth (Months, Days, Year) | Min. | June 6,1926 9. Birthplace (State or Foreign Country)
S. Carolin 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 250-34-4158 Carolina Director Usual Residence of Decedent r 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Germantown Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 0 5 5 Summer Sweet Court 20876 U.S.A. ma 23a Funeral 12. Was Decedent Evar in U,S. Armed Forças? 1 ☐ Yea 2 ☐ No If Yes, Giva Yaar or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Institutely, or its improved other than "naturaly, or its any injury or other traumatic event, the Mental any injury or other traumatic event, the Mental and Eastern or 1 Nevar Merried 2 Merried altimore, Maryland 21215-0020 Black 1 ☐ Yas 2 ZNo Specify: à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of Maryland Elementery/Secondary (0-12) Collega (1-4or 5+) 12th Housekeeper Tech 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) 8 Mattie S. Moore Warren Coclough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Janice Hagood (Daughter) 5 Summer Sweet Ct., Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 7/14/99 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part1. Enter the inscream or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one muse on each line. Approximate Intervat Between Onset and Death **Physician** /Medical tmmediate Causa (Final . BREAST CANCER WITH METASTASES YEARS disease or condition resulting to death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed **burial-transit** Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760. 4 Due to (or as a consequence of): USB 88 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yaa 2 No 3 Probably 4 Unknown ALZHEIMERS DISEASE Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? director, page 2 should Be Completed 1 Yas 2 No 1 □Yas 2 □ No certificate of Vital Hospital or Attending Physician: 25. Was casa raferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2√2 No edical Certification: To this funeral 27. Mapnar of Deeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how Injury occurred Division After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funeral Director: All completely filled in by the fu Invastigation 6 Could not be datarmined 3 Sulcide 28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida to Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiar STAFF PHYSICIAN D42046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18100 SLADE SCHOOL ROAD GANDY SPRING, MARYLAND GRACE BRORLE HUFFMAN, M.D. 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

Registrar

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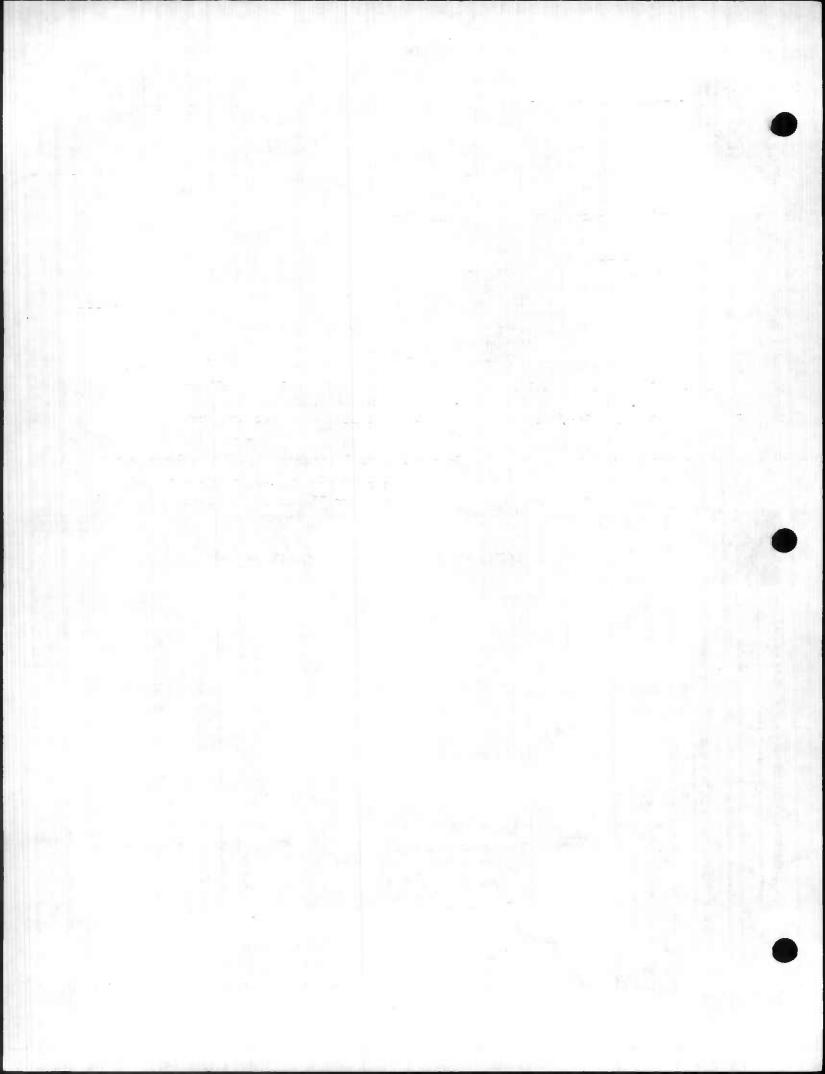
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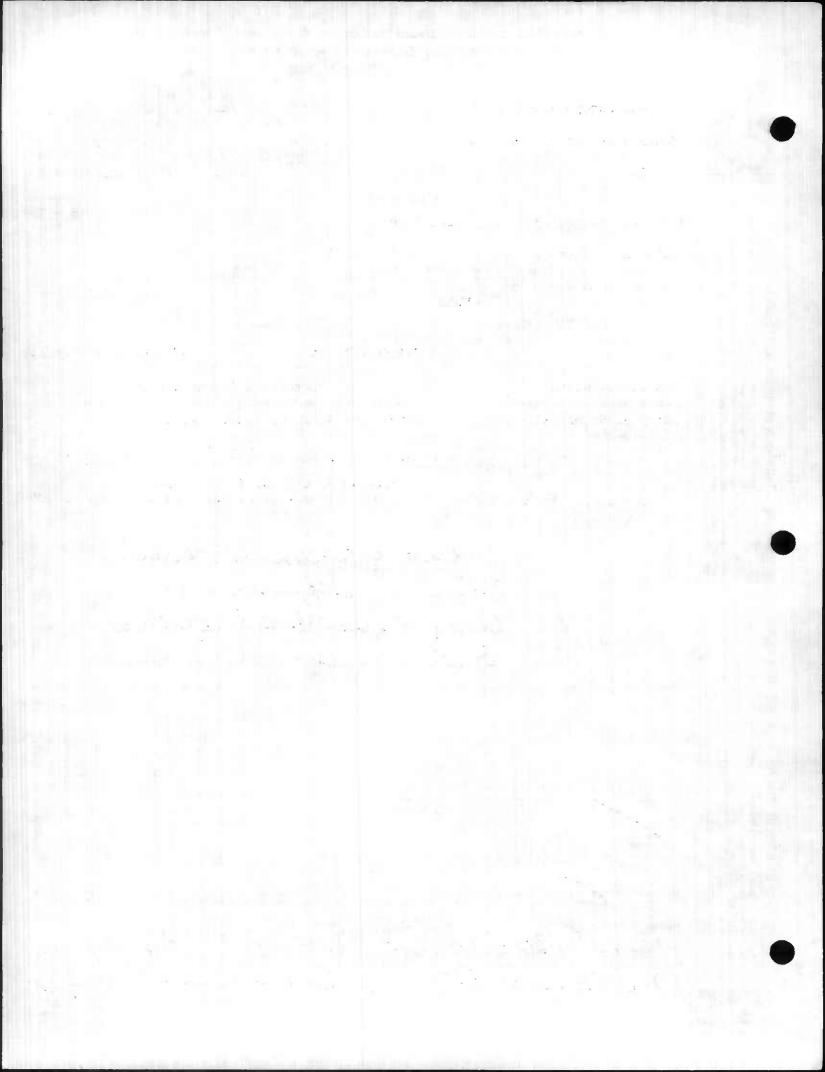
State of Maryland	Department	of Health and	Mental	Hygien
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	-				Certifica	te of	Death		Reg. No.	13	
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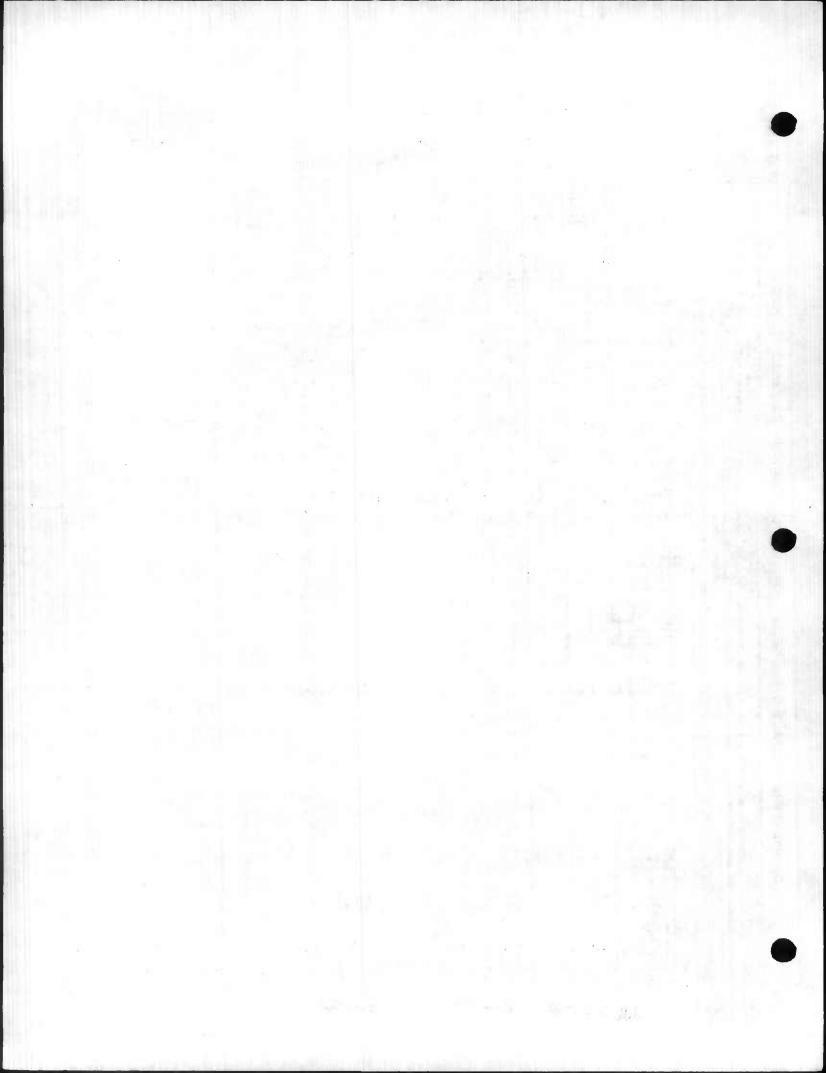
State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

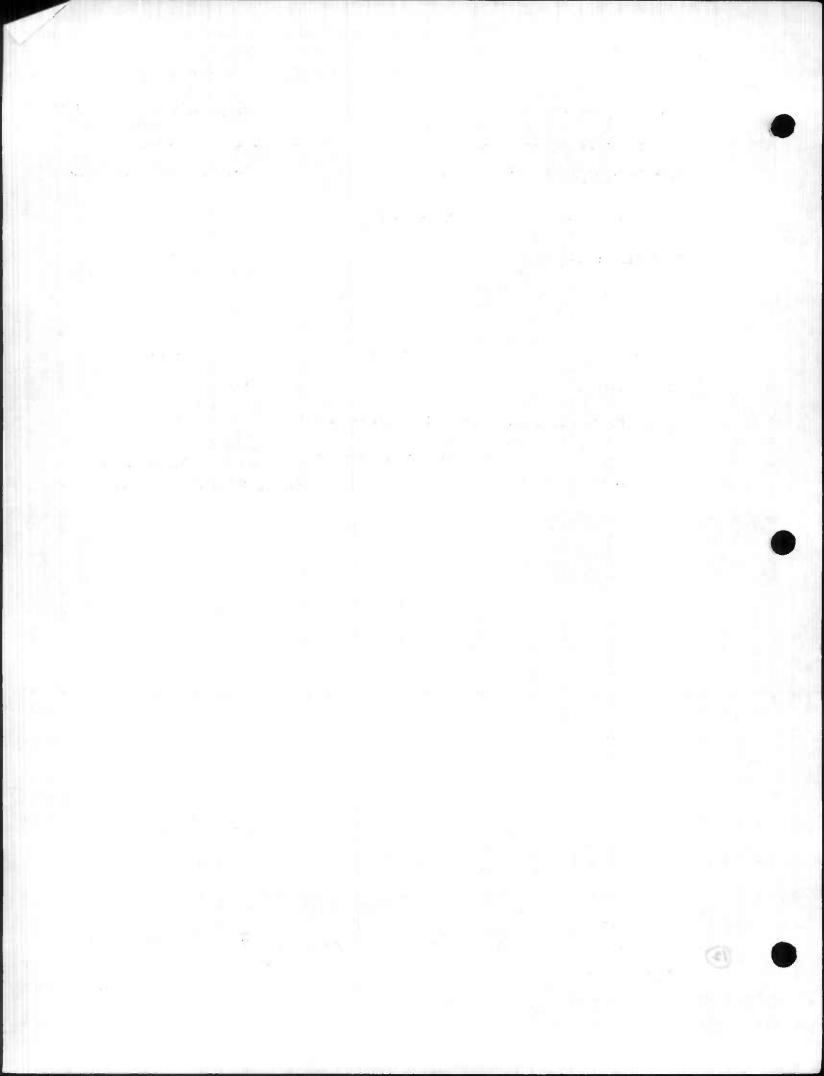
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	f Heelth fram 27 i	RICHARD WILSON, 20a. Method of Disposition	JR./SON	Ob. Place of Dispo	osition (Nama of	IDGE RD		BRIDGE 20c. Location - C		
altimore	9 9 7 7	1 DBurial 2 ☐ Cremation 3 ☐ F			matory or other pla UNT CEM					
		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens			2. Name and Addr	L	/12/99			
Ba	Departi Departi Importa any inju		1.5%			NERAL H		ILLIS		
		23a, Part Enter the disease, or complete shock, or heart tailers. List only of	ications that caused the				*****	TMINST		D 21157 Approximata
и	Physician /Medical Examiner	Immediata Cause (Final disease or condition resulting in death)	pulm		e m	bolus				niterval Between Onset and Death
oʻ	tificate be executed g physician and street buriel-transit edical Examiner		bDue	to (or as a conse	quence of):				i	
	5 00 -	resulting in death) Last	Dua	to (or as a consec	quence of):		-			
Вох	at the death cert d by the attending eteched for use Physician/M		*							
0	that the de ted by the a deteched	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	inderlying cause g	iven in Part I.				the cause of death?
Q .	that the detection by		lation				1 U Y	as 2 A	3 Probe	ibly 4 ☐ Unknown
Records,	The law requires that also been signed by page 2 should be determined.					100	24a. Was a perform	n autopsy med?	avai	e autopsy findings lable prior to pletion of cause eath?
=	The ist						104	85 2 D	10	Yes 2□ No
<u>=</u>	certificate rector, pay	25. Was case referred to medical					th (Check only or	10)		
of Vital	事品	1 Yes 2 No	The second secon	2 ER/Outpatie	nt 3LIPDOA		oma 5 Reside			
	Attending P or death. Sctor: After the funer by the funer iffication:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	W	iryat ork?]Yes 2 ☐ No	28d. Describe h	ow injury occurre	d	
Division	tel or Attending P as after death. al Director: After t ed in by the funera Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S		reet, factory, office		28f. Location (Si City or Town		r or Rural	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi	29a. Certifier 1 Certifying Physical Check only cone) 2 Medical Exami	sician: To the best of my ner: On the basis of axa and manner stated.	mination and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and mar late and placa, a	nar as sta nd due lo t	ited. tha cause(s)
	within To the comp	29b. Signature and title of certifier				se number	2	9d. Date signed	(Month, D	lay, Year)
		Motitachedu	/			200		7-8-	· ·	
		30. Nama and address of person who co	AGANNA	(Item 23a) (Type,	Print)	Rd WEST	MINSTER	MD 2	1157	
		GHIIKHUUCDW IA		1 10	0 11					



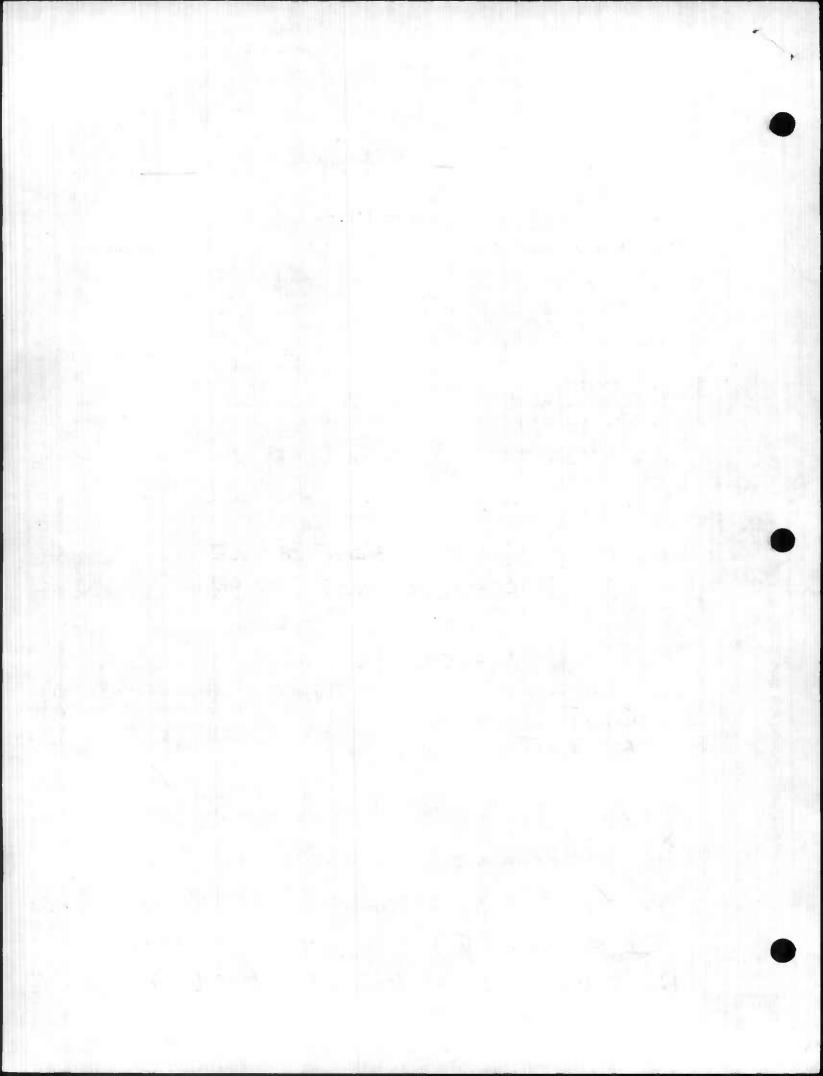
State of Maryland / Department of Health and Mental Hygiene

					iary iarre /		icate of		R	leg. No.			
	l pro-late		1. Decedent's Neme (First, Mic	ddle, Last)					2. Dete of Dee			3. Time of Deeth	
	Physici /Medi		Doris Jean Zal	briskie					July 14	.1999	Yeer	11:40 am	
	Examir		4e. Facility Neme (If not institution, give street and number)					4b. City, Town, or	Location of Deeth	4c. County	of Death		
	Funeral		Bedford Court 5. Sociel Security Number		ge (In yrs. last l	birthdav) If	S Under 1 Year	ilver Sp	ring		omery	e (State or Foreign	
	Director		216-46-7706 Usuel Residence of Decedent	1□ M 2□xF	73	Yrs.	onths Deys	Hours Mir	8. Dete of Birth (Month, Dey Nov 25	,1925	Washin	gton, DC	
	Mand Mand		10a. Stete 10b. Cour	nty	10c. City, To	wn or Location	on				10d	inside City Limits	
	Man,	tor	Maryland Mont	gomery	Silver	Sprin	ng					1 ☐ Yes 2 🖺 No	
	r 284	Director	10e. Street and Number			1	Of. Zip Code		1	Og. Citizen of V	What Country	?	
	h wit	0	1604 Timberli	ne Road		2	20904	USA					
21215-0020	is 1 and 2 should be filed within 72 hours efter deeth with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Meritel Stetus 1 Never Merried 2 M M 3 Widowed 4 Divorce	12. Wes Deceden Armed Forces 1 Tyes 2 2 If Yes, Give	PNo		Decedent of I- s, specify Cub Yes 2 2 No		Specify Yes or No- rto Rican, etc.)	Bled	ce - American ck, White, etc y: White		
0	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 College (1-4or 5+) Secretary					pation		16b. Kind of B	usiness/Indus	atry			
215						during most of wo d)	uring most of working			36. 1			
2	d wil	EO.	12	., Conege (1-40)		ecreta	ry			DC Gove	rnment	:	
Maryland	al Hy	Be	17. Fether's Neme (First, Midd	le, Last)				18. Mother's Ne	eme (First, Middle,	Maiden Suman	10)		
Va	Went Went wrked wrked	To	Irving G. Gra	У				Lillian	n Disney				
a	and a		19a. Informant's Name/Relation						iural Route Number				
	and salth		Howard F. Zab	riskie/Husbar				ne Road,	Silver S	pring,	MD 209	104	
Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other to once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	on 3 Removal from State (Specify)	ceme		n (Neme of ry or other ple Cemeter		July 16	20c. Location -		, State	
at	Departr Departr Imports any inju		21. Signeture of Funerei Service	ce License		22. Ne	me end Addre	ss of Fecility	lins Funeral Home, Inc.				
(11)	82 5 2 8		TRACOL	1 Luce	<i>></i>							MD 20901	
			23a. Peri 1. Enter the disease, shock, or heert failure. L	or complications that cause ist only one cause on each	ed the death. De	o not enter th	e mode of dyle	ng, such as cardie	oc or respiratory arr	est,	A	pproximate terval Between	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	· Arth							0	Years	
		_	resolding in death)		Due to (or es						1		
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	rificete be executed ng physician and as the buriel-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):								1		
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89	tificete g phy as the	Medical	resulting in death) Last		Due to (or as a	a consequenc	of):						
Вох	nding use a	2		d									
m	eeth cert attendin	Physician/N	Doet II Other slaudies at a see of	Maria and Anna and Anna									
P.O.	that the de ned by the a deteched	hys	Pert II. Other aignificant condi		but not resulting	in the under	lying cause gr	en in Pert I.				e cause of death?	
	thet bed b	by PI	Selzure	Prisorder					1 1 1	aa 2 No	3 Probab	oly 4 ☑ Unknown	
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00	v requir been si should	Completed	I ransien [Ischemic	1471	acks			perfor		comp	ble prior to letion of cause	
Re	The lew ate hes pege 2	m C								/	of dea		
a			25 Was seen intered to made	and .		_			1 □ Y		1 L Y	'es 2□ No	
of Vital		o Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospitel:			Oth	AT:	eth (Check only or				
o	Phys r this arai d		27. Manner of Death	1 ☐ Inpat 28a. Dete of Inj	ury 28b	Outpatient 3 Time of	LOOA	420 Nursing	Home 5 Reside				
O	ding in.	tlor	1 Neturet 5 ☐ Pend 2 ☐ Accident Inves		ay Year)	Injury	28c. Injur Wor	rk? Yes 2 □ No		,,			
Division	or Attending lefter death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Coul	ld not be 28e. Piece of Ir	njury - At home, rtc. (Specify)	ferm, street, t			28f. Location (St City or Town		er or Rural R	oute Number,	
	To the Hospital or Attant within 24 hours effer deat To the Funeral Director: completely filled in by the	edical C	29e. Certifler 1 Certify (Check only one) 2 Medica	ying Phyalcian: To the best al Examiner: On the basis of end menner s	of examination e	ge, deeth occ and/or investig	urred at the tir getlon, in my o	ne, date end plec pinion, deeth occ	e, and due to the curred et the time, d	ause(s) and me ete and plece,	end due to th	e cause(s)	
	omple of the	Me	29b. Signeture end fittin of certif		, ,		29c. Licens	e number	2	9d. Dete signe	d (Month, Da	y, Year)	
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			30. Name and eddress of perso	+1 11	/) [] e	1. 111.03	1			have me	
	Ch		31. Dete filed (Month, Dey, Yes		rer's Signeture	3 2	, J	W/3 C01	15101 /41	re Ch	1evy C	have me	
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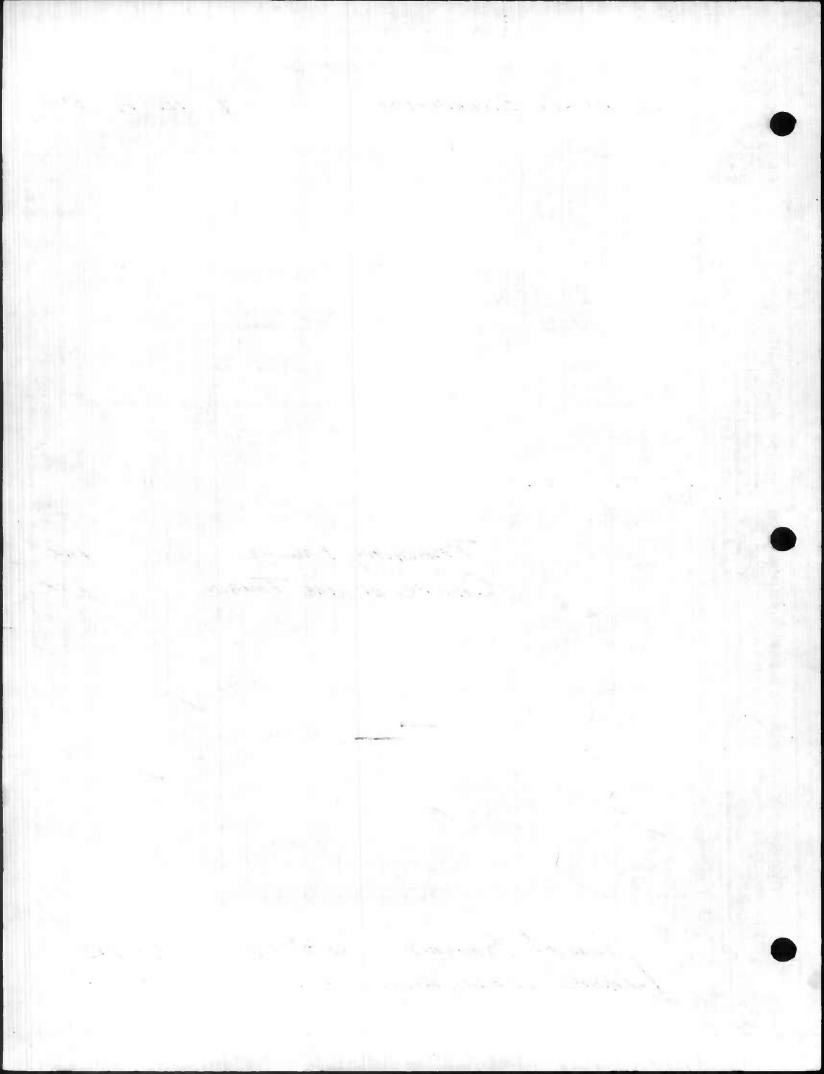


Amend #7,8	State of Maryland / Department of Health and Mental Hy, 7/22/99, BMW, Montg. Co. Certificate of Death	/giene Reg. No.
Physician /Medical	1. Decedent's Nama (First, Middle, Last) John Joseph Zanetti July	Day Year 13, 1999 11:30 AM
Examiner	4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Dea 19417 Brassie Place #104 Montgomery Villa	th 4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 1 \boxtimes M 2 \square F 7. Aga (In yrs. last birthday) H Under 1 Year H Under 24 Hrs. 8. Date of Bi (Month, D) Sept.	
the Maryland r 288-f show notified at	Usuel Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location Md. Montgomery Montgomery Village	25 , 1924 10d. Inside City Limits 1□ Yes 2 ☑ No
N N N	10e. Street and Number 19417 Brassie Place #104 10f. Zip Code 20886	10g. Citizen of What Country? United States
0020 rours after death rest, or thems 23 Estantions mass d by Funeral		Specify: White
d 21215-0020 Hydiana. Hydiana. Hydiana. Hydiana. Hydiana. Completed by Fu	15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laboratory Technician	16b. Kind of Business/Industry Printing Company
E sass W	17. Father's Name (First, Middle, Last) Angelo Zanetti 18. Mother's Name (First, Middle Louise Fresch	
OF THE PALL A.	19a. Informant's Name/Relationship (Type, Print) Hannah B. Zanetti (Wife) 19b. Meiling Address (Street and Number or Rural Route Number) 19417 Brassie Place #104 Mon	
altimore, mit. Pages 1 ar partment of Hea portant: If Nem 2 y Injury or other 68.	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 1999	20c. Location · City or Town, Stata Silver Spring, Md.
Baltimo pernit. Page Department of Important: If any injury or any injury or	Cuttes & Dey 10 East Deer Park Dr. Gat	
Box 68760, leath certificate be assecuted attending physician and Jor use as the burial-transit clan/Medical Examiner	23a. Part 1. Enter the disease, or complications that defeed the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. Congestive Heart Failure bua to (or as a consequence of): ATHERO SCLEMOSIS CORONARU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Congestive Heart Failure bua to (or as a consequence of): Coronary Due to (or as a consequence of): Coronary Due to (or as a consequence of): Coronary Due to (or as a consequence of): Coronary Due to (or as a consequence of): Coronary Due to (or as a consequence of): Coronary Due to (or as a consequence of):	Approximate Interval Between Onset and Death YR
is, P.O. Box es that the death certified by the attending be detached for use a by Physician/M		tobacco use contribute to the cause of death?
Record he law requir a has been s age 2 should ompleted	ARTHURITI) 24a. Wa perl	s an autopsy lormed? 24b. Ware autopsy findings available prior to completion of cause of death? Yas 2 No 1 Yes 2 No
/ita	25. Was case rafarred to medical examiner? Hospital: Other	one)
noral neral	27. Manpar of Death 1	idence 6 Other (Specify) how injury occurred
	3 Suicide 6 Could not be detarmined 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 281. Location City or To	(Street and Number or Rural Route Number, own, State)
To the Hospital within 24 hours To the Funeral completely filled Medical C	29a. Cartifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the (Check only one) Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time and manner stelled.	, date and place, and due to the cause(s)
12 Sommon M	29b. Signatura and titla of certifiar Paul Vullbula M 29c. License number D33719	29d. Data signed (Morith, Day, Year) 07-13-1999
	30. Name and address of person who complated cause of death (Item 23a) (Type, Brint) PAULT, WIELEBINSKI MD (8550 OFFICE Rende)	De GATHERBURG MD
State Registrar	31. Data filed (Month, Day, Year) JUL 15 1999 32. Registrar's Signatura S. Sports	



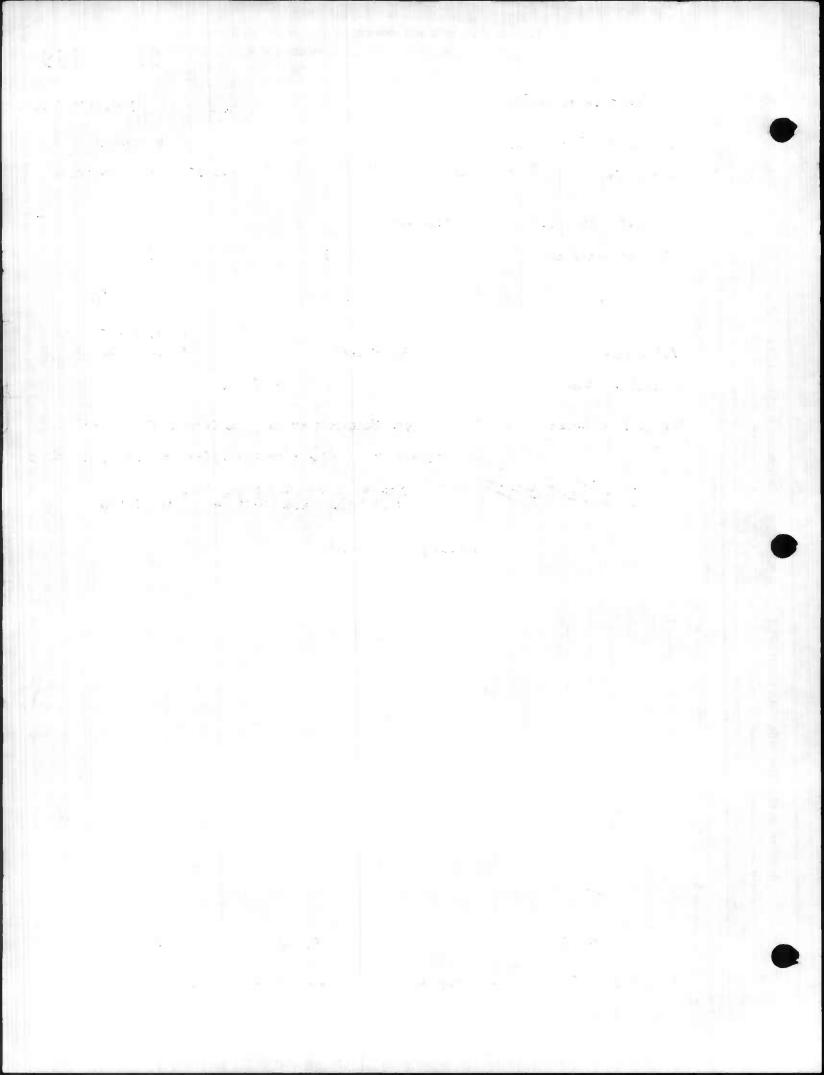
State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nama (First, Middle,					2. Data of De		3. Time of Death	
Physician /Medical	HYMAN ~	T. ZIMI	TEEM	m		Month	Day /2. 5	rear 3 PM	
Examiner	4a Facility Nama (If not institution,				4b. City, Town, o	r Location of Deat	h 4c. County o	of Death	
	SUBURBAN HOS				BETHES		MONTG		
Funeral Director	5. Social Security Number 350–34–9998 Usual Residence of Decedent	S. Sex 7. Age	(In yrs. last birtl	Months Day		8. Date of Bir (Month, Da JULY 1	9, 1914	9. Birthplace (Stata or Fore Country) NEW YORK	
Maryland H ahow	10a. Stale 10b. County	GOMERY	10c. City, Town BETHE					10d. tnside City Lim 1 ☐ Yes 2/☐?	
vith the Ma	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
23a 23a ret	7913 CHARLES	TON COURT			0817		UNITED :	STATES	
72 hours after death with the Maryland netural; or items 23s or 28s-1 ahow deal Examiner must be notified at eted by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? d 1 ☑ Yes 2 ☐ No If Yes, Give Yaar or Datas:		13. Was Decedent of If Yes, specify C		Specify Yes or No rto Rican, etc.)		- American Indian, s, White, etc. WHITE	
ed within 72 hours yglene. Mr than "natural", A, the Medical Exe Completed by	15. Decedent's (Specify only highest (16a. I	Decedent's Usual Occ	supation ne during most of w	orking	16b. Kind of Bus	iness/industry	
within iene.	Elementary/Secondary (0-12)	Collega (1-4or 5+)	Give kind of work doi life. DO NOT use ret. PHYSICIAN	ired)		GOVER	MENT	
	17. Father's Name (First, Middla, La	3.	1	HISTOIAN	18. Mother's No	ame (First, Middle	, Maiden Surnama		
0 = 0 > 0						L MARINE			
SPES	19a. tnformant's Name/Relationship	o (Type, Print)	19b.	Mailing Address (Stre	et and Number or F	Rural Route Numb	er, City or Town, S	State, Zip Code)	
Health a Health a sem 27 learn	DIANE ZIMMERMAN	(DAUGHTER)				- BETHES	DA, MARY	LAND 20817	
Pages nent of int: If it	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			Disposition (Name of crematory or other position) VID MEM. (7/15/99		City or Town, Stata HURCH, VIRGIN	
permit. Pag Department Important: t any injury o	21. Sign and Service in	Signe			Y-GOLDBER			LS, INC. RYLAND 20852	
Physician	23a. Part1. Enter the dise, se, or co shock, or haart tailure. List o	mplications that caused the cause on each line	he death. Do no					Approximate Interval Between Onset and Death	
/Medical	Immediate Cause (Final disease or condition resulting In death) a. RESPIRATION FAILURE Due to (or as a consequence of): MICER OF THE TONGUE								
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5	disease or condition	8.	CESPI R	ponsequence of):	FAILUR	E		1412	
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es that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit by Physician/Medical Examiner	disaase or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last	c	ue to (or as a co	onsequence of):		23b. Did	tobacco use con	/ Y/C	
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The law requires that the death certificate be associted at has been signed by the attending physician and page 2 should be detached for use as the burlat-transit completed by Physician/Medical Examiner	disaase or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last	cDi	ue to (or as a co	onsequence of): onsequence of): the underlying cause	given in Part I.	23b. Did 1 2 24a. Was	tobacco use continues 2 No san autopsy ormed?	tributa to the cause of dear 3 Probably 4 Unknown 24b. Were autopsy tinding available prior to completion of cause of death?	
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Physician: The law requires that the death certificate be associted this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit at director, page 2 should by Physician/Medical Examiner: To Be Completed by Physician/Medical Examiner	disaase or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algnificant conditions 25. Was case reterred to medical examiner? 1 Yes 2 No 27. Manner of Ceath 1 Natural 5 Pending	d	ue to (or as a co	consequence of): consequence of): the underlying cause constinct 3 DOA me of 28c. In ury	given in Part I. 26. Place of D. Other: 4□ Nursing	23b. Did 10 24a. Was perli	tobacco use continues 2 No	tributa to the cause of dear 3 Probably 4 Unknown 24b. Were autopsy tinding available prior to completion of cause of death? 1 Yes 2 No	
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State of Maryland / Department of Health and Mental Hygiene 9 2 3 5 5 9

				Certificate	e of Death	Re	g. No.	20000				
	Physician	1. Decedent's Neme (First, Middle, La Charlotte A.				2. Data of Death Month	Day	3. Tima of Death				
	/Medical				4.00.7	July		1999 12:30 a.m.				
	Examiner	4a Facility Neme (If not institution, give				or Location of Deeth	4c. County					
		Stella Maris Ho			Timonu			imore				
	Funeral Director	5. Social Security Number 6. S 216-36-8546 Usuel Residence of Dacadant	Sex 7. Aga (In yrs. I	Ast birthday) If Under Months		fin. 8. Data of Birth (Month, Day, Oct. 29	Year) , 1939	9. Birthplace (State or Foreign Country) Maryland				
	and w	10e. Stete 10b. County	10c. City	y, Town or Location				10d. Insida City Limits				
	ifier deeth with the Mary r terms 23a or 28a-f shu cher must be notified a Funeral Director	Maryland Harfor	d Edg	gewood 101. Zip	Code	11	og. Citizan of W	1 ☐ Yes 2 🕅 No				
	34 or	1222 Chipper Driv	0		040		U.S.A					
	ms 2	11. Marital Status	12. Was Dacedant Evar in U.		dent of Hispenic Origin? city Cuban, Maxican, Pu	(Specify Yes or No-	14. Race	- American Indien,				
21215-0020	urs e urs e Dv	3 □ Widowed 4 ☑ Divorced	Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Dates:	it Yas, spec		iario Hican, atc.)	Specify:	k, White. : White				
5-0	"natural",	15. Decedant's E (Specify only highast gro	ducation ada complated)	16a. Decedant's Usua (Giva kind of woo	al Occupation rk dona during most of sa retired)	working		sinass/Industry				
121	ygiene. Nor than "natura nt, the Wedcal	Elamantary/Secondary (0-12) 10th grade	Collaga (1-4or 5+)	Bus Driv				re County Schools				
9	Hygid Hygid)	5003 0,000		Nema (First, Middle, A						
Maryland	Mental H Mental H arked out atic ever	I but to their	,			Torre						
ary	and Man	19a. Informant's Neme/Ralationship (Type, Print)	19b. Mailing Address	(Street and Numbar or	Rural Route Number	City or Town,	Stata, Zip Coda)				
	and 2 palith of 127 le	Cheryl Lynn Hobso	n (Daughter)	7400 Virg	inia Avenu	e. Baltimo	re. MD	21236				
ore	of Herrorth	20a. Method of Disposition 1 1 Day Burial 2 □ Cramation 3 □	Demousl from Ctate	amata <i>ry, cr</i> amatory or o	tnar placa)							
Ë	ment and: H	4 Donation 5 Other (Special	(y) Med	adowridge M	lemorial Pa	rk 7/27/99	Elkri	dge, Maryland				
Baltimore,	permit. Peges 1 and 2 should be filed within 72 ho Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "nature any Injury or other traumatic event, the Medical ance. To Be Completed	21. Signatura of Funarai Sarvice Lice 23a. Part1. Entar tha disaese, or com shook, or heart tailura. List only	nsaa	22. Nama an Schimun	d Addrass of Facility ek Funeral	Home, Inc	• 110 0	1441				
	COMPANY.	23a. Part1. Entar tha disaese, or com	plicetions that causad the deeth	n. Do not enter the mod	lack Koad, le of dying, such as care	diac or respiratory arre	st,	Approximate Interval Batween				
J	Physician	Shook, of Heart tailura. List only	Ona causa on aach inia.					Onset end Deeth				
и	/Medical	Immediate Cause (Final disaasa or condition	Lun	9 Can	cer							
	Examiner	rasulting in daath)	Dua to (o	ras e consequence of):								
	nine		b									
-8	death certificata be associted attending physician and dor use as the bunk-transit sician/Medical Examiner	Sequentially list conditions, if any, leeding to immadiata	Sequentially list conditions, if any, leeding to immadiate causa. Enter Underlying Ceuse, (Disaase or Injury c.									
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Box	th cer rendir		d									
	s dear he att med fo	Part II. Other significant conditions of	contributing to death but not rasu	ulting In the underlying c	ausa given In Part I.	23b. Did to	bacco use cor	ntribute to the cause of death?				
P.0	that the death certified by the attending detached for use a grand Y Physician/Me					1 🗆 Y	e 2□ No	3 Probably 4 Unknown				
JS,	8 88 6							24h Ware autosay findings				
Records,	The law requires that tate has been signed to page 2 should be delto Completed by Pl					24a. Was a perform		24b. Wara autopsy findings available prior to completion of cause				
Rec	8 2 N D	•						of death?				
	certificata haractor, page					1 D Ye		1 Yes 2 No				
of Vital	Physician: this certific ral director, To Be (25. Was case rafarrad to medical axaminar? 1 Yas 2 No	Hospital:	50/0	Othor	Death (Check only on		ar (Specify) Husnice				
o	Physic rthis coursel direction 7: To	27. Mannar of Death	28a. Data of Injury (Month, Day Year)	ER/Outpatient 3□ DC 28b. Time of 2	28c. Injury at Work?	g Homa 5 Raside		1-1-1-1				
ion	offing stion	1 ☑Netural 5 ☐ Pending 2 ☐ Accidant Investigatio		Injury M	Work? 1 ☐ Yes 2 ☐ No							
Division	tal or Attending P is after death. of Director: After tied in by the funera Certification:	3 ☐ Suicida 6 ☐ Could not be determined	28e. Placa of Injury - At he building, atc. (Specify	oma, farm, straat, tactory	/, office	28t. Location (St City or Town	reet and Numb	er or Rural Routa Number,				
Ö	s after	- Tomode	building, atc. (Specif)	<i>''</i>		Ony or Your	i, Otolay					
	To the Hospital or Attending Physicien: The i within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Cartifiar 1 Certifying Pt (Check only one) 2 Medical Example 1	nystclan: To the best of my known ther: On the bests of axaminat end mannar stated.	wledge, deeth occurrad tion and/or Invastigation	et tha tima, deta and pi , in my opinion, death o	ace, and due to the co courred at tha tima, do	ause(s) and me ata and pleca, a	nner as stated. and due to the cause(s)				
	To the comp	29b. Signal are end titla of cartifiar			c. License number	2	9d. Data signed	(Month, Day, Year)				
		1200			D43725		7/26	5177.				
		30. Nama and addrass of person who		23a) (Type, Print)	D. A.	. 1 0 .	P 10.	2/22/ nure MD				
		31. Dete filad (Month, Day, Year)	HMOUT 201-		KIVEY NO	cic read	591An	nure MD				
	State Registrar	JUL 2 7 1999	Server Signa	South	,							



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death JULY 23, 1999 LEON APPLEFELD 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth ARDEN COURTS NURSING HOME PIKESVILLE BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 2,1905 5. Social Security Number 6. Sex 1 M 2 ☐ F If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months 220-07-9362 94 Yrs MD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No N/A BALTIMORE 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 7211 PARK HEIGHTS AVENUE #201 21208 U.S.A. 12. Wes Decedent Ever in U,S Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 212 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) ATTORNEY LAW 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) (UNKNOWN) LOUIS APPLEFELD ETTA 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY APPLEFELD / WIFE 7211 PARK HEIGHTS AVE. #201 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARLINGTON CHIZUK AMUNO 7/26/99 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Juneral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart teilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting In deeth) minute Due to (or as a consequence of) CAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? 3 Probably ♣ Unknown 1 ☐ Yaa 2 ☐ No 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Вета 23а death

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or item eny injury or other treumatic event, the Medical Examinations.

altimore, Maryland 21215-0020

Examiner must be notified at

Director

Funeral

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Completed

Be

2

MD

the Manyland

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physician and s the burial-transit The law requires that the death certificete be axecu 68760, for use as 65 Box P.O. | ate has been signed by the page 2 should be detached Records, Division of Vital Hospital or Attending Physicien: director. this

Medical Certification: To After

Physician/Medical Examiner þ

Be Completed

death. after deat Director: completely lilled in by the within 24 hours a To the Funeral C ŝ 0

State Registrar 29b. Signature end title of certifier

5 Pending investigation

6 Could not be determined

25. Was case referred to medical axeminer?

1 Yes 2 No

27. Menner of Death

1 Neturel

2 Accident

3 Suicide

29e. Certifier

4 Homicide

1 Inpatient

28a. Dete of tnjury (Month, Day Year)

TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and menner steted. 29c. License number

2 ER/Outpatient 3 DOA

28b. Time of

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Injury

37577

26. Placa of Death (Check only one)

Baltne

29d. Dete signed (Month, Day, Year) 23, 1999

80515

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 ☐ Yes 2 ☐ No

1 Yes ZENo

Other: 4 Nursing Home 5 Residence 620ther (Specify)

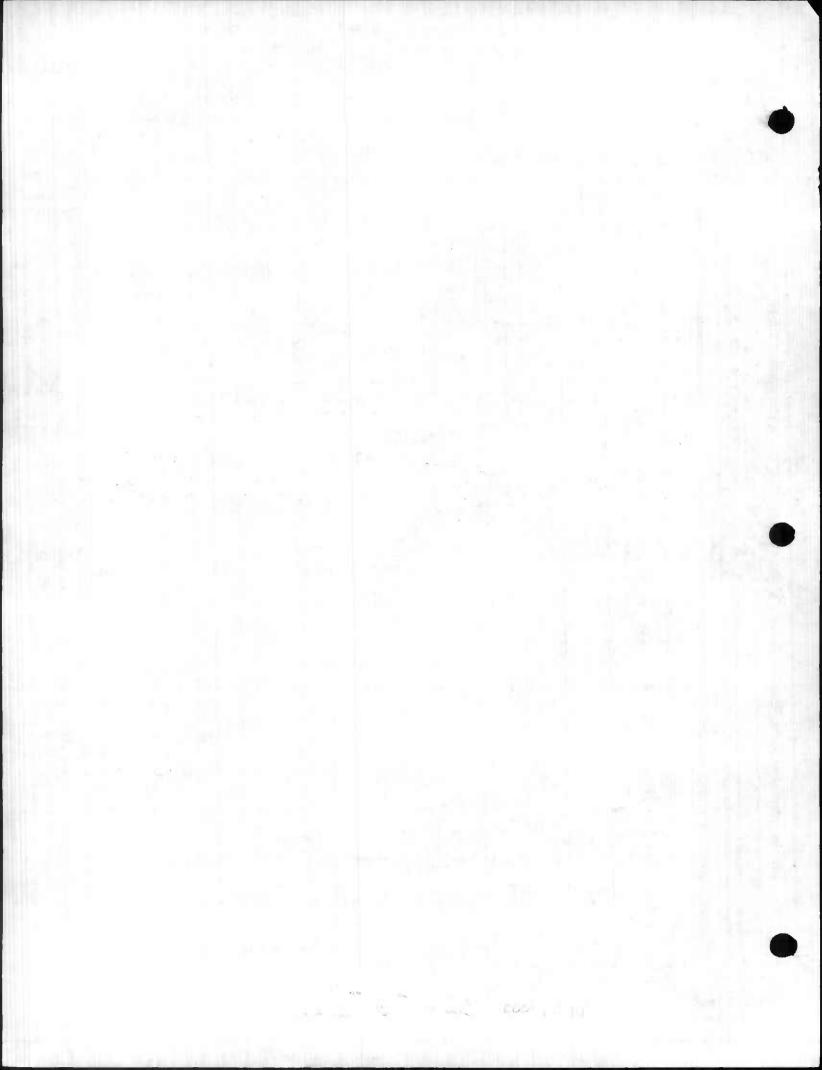
28d. Describe how injury occurred

30. Name and address of Jerson who completed cause of death (ttem 23a) (Type, Print) Park

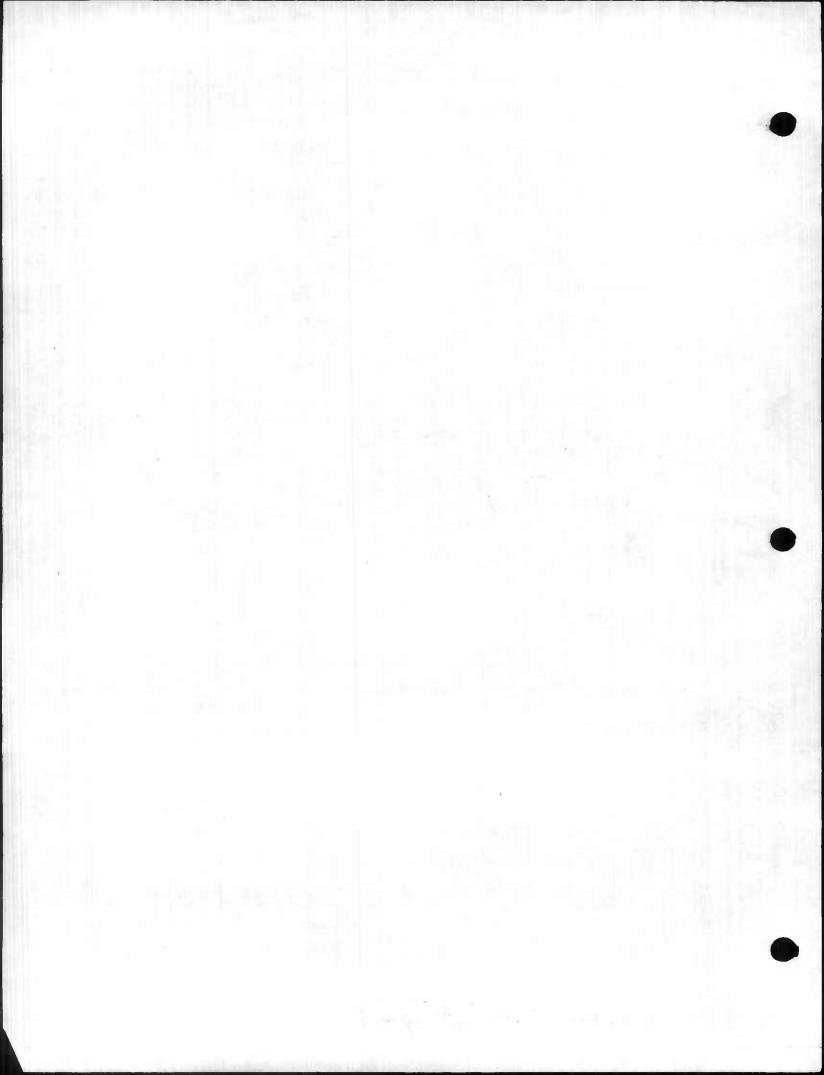
MD Modis 7770 31. Date tiled (Month, Dey, Year) 32. Registrags Signeture JUL 27 1999

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

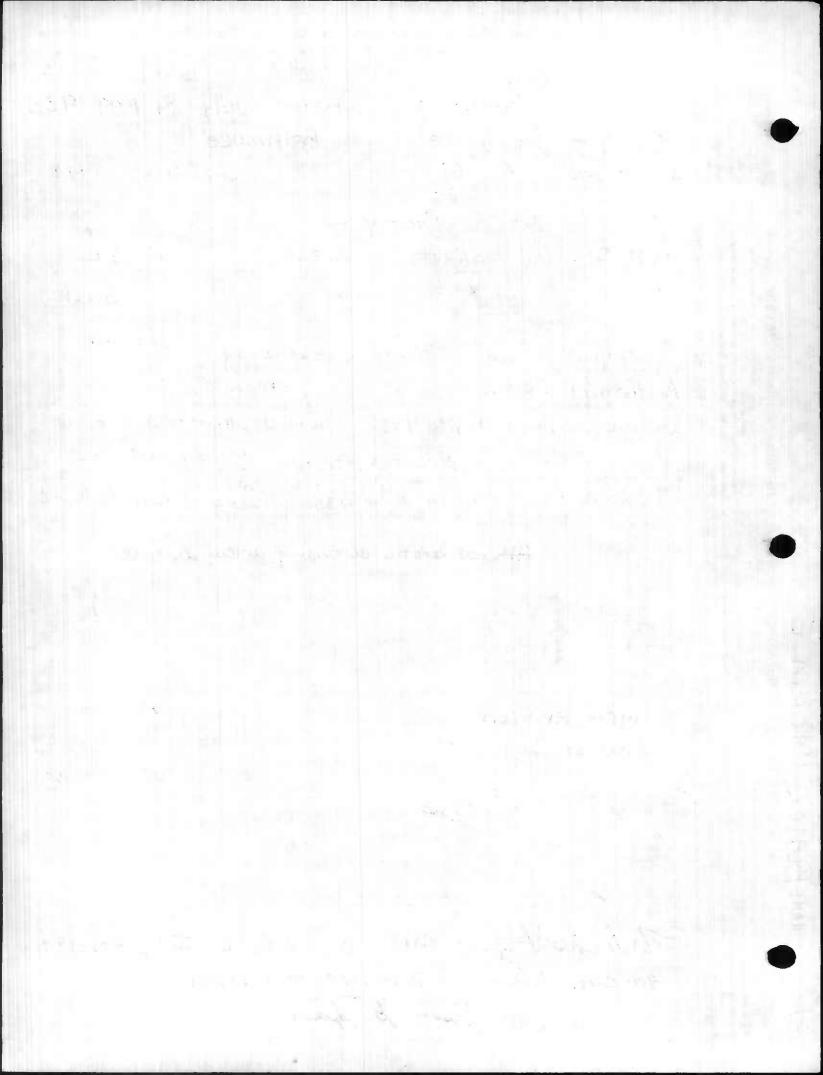


		State of Maryla	•	nent of F			eg. No. 99	23	3561
Physician /Madisa		Thomas L. (Brown			2. Deta of Dear Month July	Dey	Year 99	3. Time of Death 8:30pm
/Medica Examine	4- 57- 101- 54- 445 - 4 2 41- 41		J. 0.111	1	4b. City, Town, or Lo	cation of Death	4c. County o	of Death	
	1619 N. Durham St	reet			Baltimore	9	N	A	
Funeral Director	220-03-9377	Sex 7. Age (In yr		Inder 1 Yeer oths Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, 06-08	Year) -20	9. Birthpla Country VA	ce (State or Foreign y)
pu .	Usual Residence of Decedent 10a. Stete 10b. County	100.6	City. Town or Location				_	100	d. Inside City Limits
f sho			altimore					100	T∑Yes 2 No
the redth	10e. Street and Number			f, Zip Code		1	0g. Citizen of W	hat Country	v?
38 or	1619 N. Durham	n Street		2121	3		USA		
ire, Maryland 21215-0020 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Exercise man be notified at	MD NA 10e. Street and Number 1619 N. Durhar 11. Meritel Stetus 1 Never Merried 2 Merried 350 Widowed 4 Divorced	12. Waa Decedent Ever in Armed Forcea? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datea:	If Yea,	Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto i Specify:	ocify Yea or No- Rican, etc.)	14. Rece	- American	c.
though the same	15. Decedent's E	-15.54	16a Decedent's	Usuel Occur	nation	-	16b. Kind of Bus	Blac	
21215-0020 d within 72 hours af giene. or than "natural", or the Medical Event	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12) 6th Grade	College (1-4or 5+) NA	(Give kind of life. DO No.		eation during most of worki d)				Steel Co
Hisd other	17. Father's Name (First, Middle, Last	1)			18. Mother's Name				
Vian Wental	Thomas L. H	Brown, Sr.			Elizab	eth		Fow.	lkes
e, Maryland 1 and 2 should be file Health and Mental Hy em 27 is marked other ther treumatic event	19a. Informant's Name/Relationship Clarice Wat	(Type, Print) LSON	19b. Meiling Add 1619 N	drese (Street	end Number or Rura cham Str	<i>Route Number</i> eet Ba	City or Town, S ltimor	State, Zip C e , Mai	code) 21213 ryland
0 90- 5	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Dopation 5 ☐ Other (Speci	Removal from State	Place of Disposition cemetery, crematory	or other place			20c. Location - C		n, Stata
Baltimo	21. Signature of Funeral Service Lice	^	22. Nan	ne end Addre	ss of Fecility	00 54	Dare	111101	27112.
Balt permit. Departi Importu eny inj	1 anessa	Rings	Mar 110	ch F/I	H East North Aver	nue Bal	timore,	Md 2	1202
Physician	23a. Part1. Enter the disease, or con shock, or heart feilure. List only	polications that caused the devone ceuse on each line.	eth. Do not enter the	mode of dylr	ng, such aa cardiec o	r respiratory err	est,	1 6	Approximata nterval Between Onset and Deeth
/Medical Examiner	Immediate Cause (Fine) disease or condition		olon Can	185				18	KM SM
	resulting in death)	Due to	Due to (or as a consequence of):					1	
la in the second	b								
68760, ficate be executed physician and is the burial-transit	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
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									,
DOC requir						24a. Wes e perform		evail	e autopsy findings lable prior to pletion of cause eath?
	5					1 D Y	es 2000	10	Yes 2000
Vital I					26. Place of Deeth	(Check only or	ne)		
- 5 00		Hospital: 1 Inpatient 2	☐ ER/Outpatient 3[DOA Oth	ner: 4 Nursing Hor	ne 5 Reside	ence 6 Othe	r (Specity)	
%0 0		28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injui Wor	y et rk? Yes 2 □ No	28d. Describe h	ow injury occurre	d	
DIVISION of the standing Part of the standing Part of the standing Part of the standing part	3 Suicide 6 Could not be determined		home, ferm, street, fe	ectory, office		28f. Location (Si City or Town	treet and Numbe n, State)	er or Rural i	Route Number,
DIVISION To the Hospital or Attending within 24 hours after Geath. To the Funeral Director: After completely filled in by the fun Medical Certification		nysician: To the best of my ki miner: On the besia of examination and menner steted.	nowledge, deeth occu netion and/or investig	irred et the tir etion, in my o	me, date and place, a pinion, death occurre	and due to the cased at the time, d	ause(s) end mar late and place, s	nnar es stal nd dua to t	led. he ceuse(s)
vithin of the complete of the	E 29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed	(Month, Di	ay, Year)
- 3 - 0	I m				039409		7/26/9	9	
	30. Name and address of person who			15	Br-Tung	ma 2	1221		
State	21 Date filed (Month Day Year)	- 32. Registrer's Sig	neture South	-		41 , 60	- 1		
Registrar		were to	9. Sport	2					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middla, Last) **Physician** 110ria ul /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** teathcape Baltmore
If Undar 24 Hrs. 8. Data of If Under 1 Year 9. Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) 1 M 2 KF Months Days Hours Min. 216-36-3172 Usual Residence of Decedent Yrs. Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumetic evant, the Medical Examiner must be notified at 1 Yes 2 No Md Director Saltimore 10f. Zlp Code 10e. Street and Number 10g. Citizen of What Country? ŏ 4900 238 Street 21229 u Funeral should be filed within 72 hours efter death 12. Was Decedant Evar in U.S. Armed Forces? 1 ☐ Yes 2 5 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 1 Nevar Marriad 2 Married ŏ Black Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) al Hygiene. HOSpital Elemantary/Secondary (0-12) College (1-4or 5+) 2019 racke Hssistance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If Itam 27 is marked ot athanie erond 1son 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) AptD Balto, red Williams Daughter Wanda Place of Dispos cametery, crem 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21215 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F. H. Balto, red 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** Atherosclerotic /Medical Immediate Causa (Final coronary disease or condition resulting in death) Examiner Examiner attending physician and for use as the bunal-tran Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Dua to (or as a consequenca ol): Physician/Medical Dua to (or as a consequenca of): NAME BUTHER, GloRIA USB as I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 46 3 Probably 4 Unknown Hypertention Completed by 24b. Were autopsy findings available prior to completion of cause of death? Breast Cancer 24a. Was an autopsy performed? 1 ☐ Yes 2500 t Non After this certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 Yes 2 🗌 No To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 🗲 certifying Physician: To the best ol my knowledge, death occurred at the time, date and place, and due to tha ceuse(s) and manner as stated. Medical 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. Licensa number 29b. Signatura and tile of certife 29d. Date signed (Month, Day, Year) MD D0053312 24,1999 July 30. Name and address of person who complete causa of da 900 Catro Avenue causa of death (Itam 23a) (Type, Print) Baltimore, MD 31. Data liled (Month, Day, Year) 32. Registrar's Signature State Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 23563 Certificate of Death Reg. No 2. Deta of Daath 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4:25pm Month Day 25 **Physician** Brice 120, 4b. City, Town, or Location of Death /Medical 4c. County of Deat 4a Fscility Nama (If not Institution, giva street and number) Examiner Bultimore Sinai Hospital CITY If Undar 24 Hrs. If Undar 1 Yaar 9. Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 8. Data of Birth 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 720-38-7923 Usuel Rasidance of Decedent Min. 1□M 20F Months Deys Hours Yrs. Director the Maryland 10b. County pernit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experience must be notified an once. 10e. Steta 10c. City, Town or Location 10d. Insida City Limits 1 XYes 2 □ No Md Director A 10f. Zlp Coda 10g. Citizen of What Country? 10e. Street and Number S. Rd. 21215 OKC 381 hester Funeral 14. Reca - American Indian, 12. Wes Decedent Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 11. Marital Status Black, White, atc. 1 Yas 2 No If Yes, Giva Yeer or Dates: 1 Naver Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 200 Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade complated) (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) WORK House A 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Elizabeth Simmons DAVERDORI 1insley 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Jeffre 381 Baltimore Md. 21215 (50n) JORCHESTER ed. BRICE 20c. Location - City or Town, Stata 20a. Mathod of Disposition 20b. Pleca of Disposition (Neme of cematary, cramatory or other place) Data 1 Suriel 2 Cremetion 3 Ramoval from Stata -3-99 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signuture of Funaral Sarvice Licensee 22. Nama and Address of Fecility 1129 BAltu. N. CACOLINE Md. 21213 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intarval Between Onset end Death **Physician** Encephalopathy secondary to renal furture
Dua to (or as a consequence of):

end stage Immediata Causa (Final disaasa or condition resulting in death) /Medical **Examiner** Examiner physician and the burial-transit requires that the death certificate be executed Sequantially list conditions, if any, leeding to immadiate causa. Enter Underlying Cause (Disaase or Injury Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical that initieted events rasulting in death) Last Due to (or es e consequance of): 98 980 ō Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Fullure Secondary Congettic heart fallure 10 Àq 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s has 1 ☐ Yes 2 ☐ No certificata 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this luneral 28a. Data of Injury (Month, Day 28c. Injury at Work? 28d. Describe how Injury occurred 27. Mannar of Death 28b. Tima of Certification: or Attending Natural 5 ☐ Panding after death. Director: Aft 1 ☐ Yes 2 ☐ No Invastigation P 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) n 24 hours after des re Funeral Director blataly lilled in by th 6 Could not be datamined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune complately II (Check only one)

State Registrar

31. Data filed (Mo

29b. Signature and title of certifier

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print)

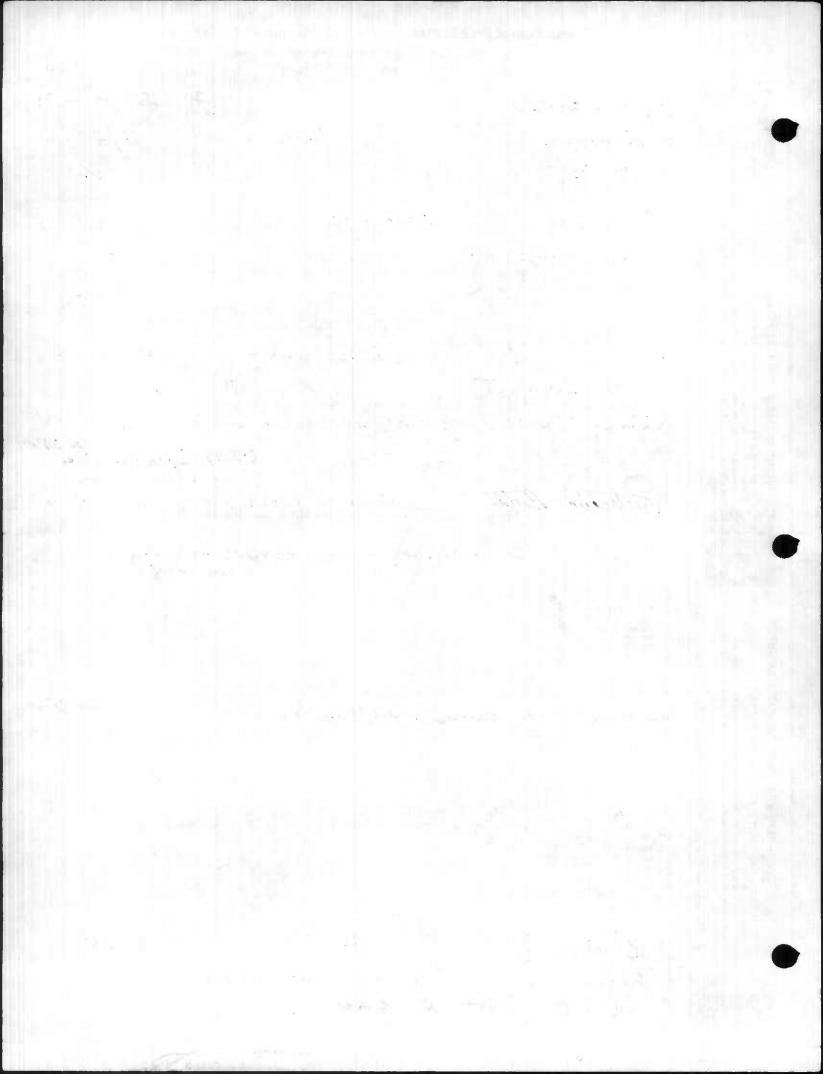
Arthur Li, MA Sina Hog SINA 32. Registrar's Signeture

Hospital of Bultmore

29c. License number

REG-000

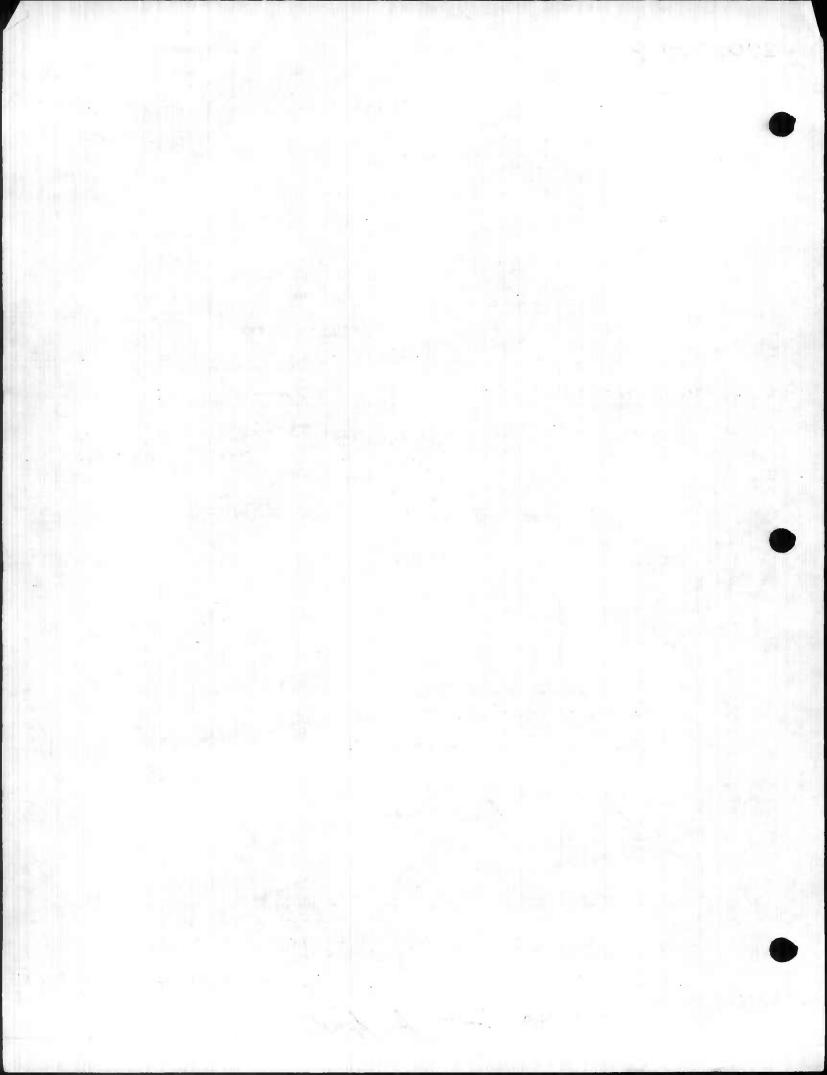
29d. Date signed (Month, Day, Year) July 25, 1999



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	Physicia: /Medica	1	RUF US			BRI	AC	EY	2. Date of Di Month	25, 19	199 5	ime of Death : 44 Ph
	Examine Funeral		a Facility Name (If not institution, GOOD SAM) Social Security Number	ARITAN Sex 7. Age	HOS e (In yrs. last I	PITAL birthday) If Und Month	er 1 Year	b. City, Town, or BALTI If Under 24 Hrs Hours Min.	MORE J 8. Date of Bi	BALT	9. Birthplace (CITY State or Foreign
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Maryland	H to M	0 0	7. Father's Neme (First, Middle, Le W L C B 19a. Informant's Name/Relationship	RACRY	19	9b. Mailing Addre	ss (Street a	Elens	e Wo	Maiden Sumam)
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Balti	pemit. Peg Department Important: I any injury c phos.		21. Signature of Funeral Service Line 22. Signature of Funeral Service Line 22. Part Filter the disease, or conshock, or heart feilure. List or	b. Lock	the death. D	Jose	Eh 1.	s of Facility LLL g, such as cardial	16 Ju	7/1 130 c	4h. Chi	ALL DY
	Physician /Medical Examiner	1000	mmediate Cause (Final diseasa or condition esulting in death)	a	Sei	DS IS						days
	be executed siclan and buriel-transit	Examinie	Sequentially list conditions, I any, leeding to immediate lause. Enter Underlying	b	Due to (or as	a consequence o	():					
x 68760,	ficate be physicials the bur	ti ca	Jause (Disease or Injury hat initiated events esulting in death) Last	c	Due to (or as a	a consequence of):					
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Division of Vital Record	r Attendent frector: in by the		2 Accident investigal 3 Suicide 6 Could no determine	be one Dines of leis	ary - At home, c. (Specify)	M farm, street, facto		Yes 2□No	28f. Location City or To	(Street and Numb wn, State)	er or Rural Rout	ie Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled I	2	9a. Certifier 1 Certifying. (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination a	ge, death occurre and/or investigation	d at the lim on, in my op	re, date and place pinion, death occu	, and due to the irred at the time	causo(s) and ma , date and place,	and due to the c	ause(s)
	within Toth comp		9b. Signature and title of certifier	,	M.D	-	9c. License	number 1140	2	JULY		,
		h	0. Name and address of person who will IAM IMBEA	HI,GOOD SA	MARITA) (Type, Print) AN HOSPT	TAL,	5601 LO	HRAVE	IN BLVD	BAL	TIMORI 1239
	State Registrar		1. Date filed (Month, Day, Year)		ar's Signature	4	/				14(1) Z	1 4-21

DHMH 16 Rav 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 99 Certificate of Death 3. Time of Death Pm 1-Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** 18 /Medical 4c. County of Death 4e Facility Neme (II not Institution, give street end number) 4b. City, Town, or Location of Death Examiner Medica BAltomore Mulfi-Mu 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) WSON enter If Under 1 Year 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Deys 10 M 35 F Months Yrs. 212-24-0619 71 11, Director April 1928 Maryland Usual Residence of Decedent with the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 8438 Kavanagh Road 21222 United States death Funeral Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 12. Wes Decedant Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Stetus Black, Whita, atc. nours after 1 ☐ Yes 2 ☐ No If Yes, Giva 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 42 Divorced Yaar or Dates: White Completed 15. Decedant's Education (Specify only highest grada completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry ifiled within 7 I Hyglene. Elementary/Secondary (0-12) 12 Years Collega (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien, Important: If them 27 is marked other that any Injury or other traumests. Tractor Operator Bethlehem Steel 17, Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Leo Fahey Marie Tice 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Mr. Richard P. Bray 9311 Beowulf Circle Baltimore, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7/22/99 4 ☐ Donation 75 ☐ other (Specify) Towson, Maryland 21. Signature of Juneral Service License 22 Name and Address of Facility Duda-Ruck Funeral Mome of Dundalk, Inc. Dundalk, Maryland Past . Enter the disaesa, or complicitions that cursed the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on mich line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Causa (Final Reumonia Days disease or condition rasulting In deeth) Examiner Due to (or as a consequence of): mexten Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequenca of): P.O. Box 68760. ear Herioscerosis Physician/Medical Dua to (or as a consequenca of): the th 88 ò Part II. Other atgniftcant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Dtd tobacco use contribute to the cause of death? signed by t 1 Yea 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen : 1 Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yas 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28a. Place of Injury - At home, term, street, tectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide edical 29a. Cartifier 🔀 Certifying Physician: To the best of my knowledga, daath occurred at tha time, date end place, end due to the cause(s) and manner as stated. □ Medicat Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. Licensa number

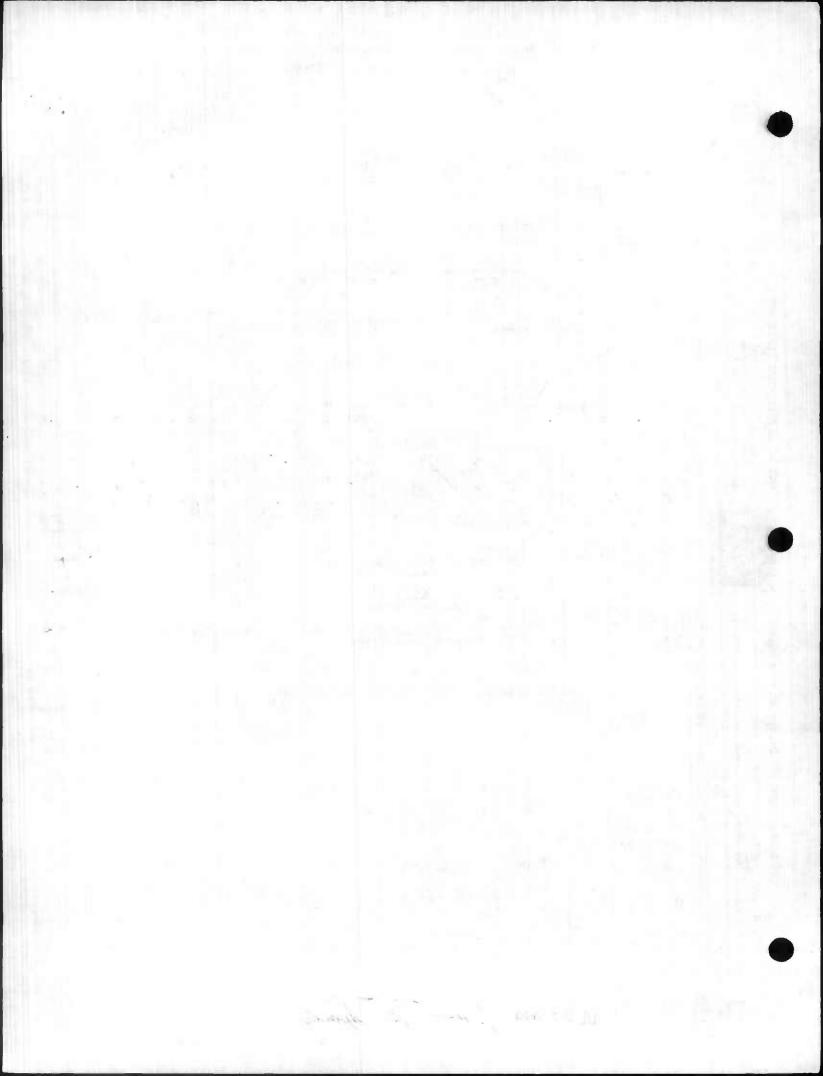
DHMH 16 Rev 6/95

State Registrar

31. Data filed (Month, Day, Year) JUL 27 1999

32. Registrac's Signature "per

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) 4920 Comphell BLVD Balto MD 21236.



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** BORNHEIM MARGARET 11:30 AM JULY 26, 1999 /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner GENESIS ELDER CARE HAMMONDS LANE CENTER BROOKLYN PARK ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months 1□M 2 F MARYLAND 79 218-09-6014 Director FEB. 9, 1920 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow ms 23s or 28s-f show 1 Yes 2000 Director MARYLAND ANNE ARUNDEL LINTHICUM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21090 U.S.A. 520 CLEVELAND ROAD Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "not other traumed. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Neme ; 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian 11 Marital Status Black White etc. 1 Never Married 2 Married WHITE 1 Yes 2 XNo Specify: Specify: à 3 ☐ Widowed 4 🏻 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) CLERK RETAIL SALES 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be **GEORGE** KAHL EMMA STEWART 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) DONALD DENNIS BORNHEIM 520 CLEVELAND ROAD, LINTHICUM, MD. 21090 (SON) 20b. Place of Disposition (Name of 7/ Paten 999 20c. Location - City or Town, Stata 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CENTER, LLC. STEVENSVILLE. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, ahock, or haart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ACUTE MYDCARDIAL INFARCTION HOUR /Medical Immediate Cause (Final disease or condition resulting In death) Examiner ANTERIOSCUEROTIC CARDIOVASCULAR Physician/Medical Examiner that the death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Box 68760, physician s the buria Due to (or as a consequence of): 88 been signed by the a should be detached f 23b. Dtd tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 tDYes 2MNs 1 ☐ Yes 2 ☐ No certificate funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Investigation 1 Natural 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rurel Route Number, City or Town, Steta) 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital Medical 29a. Certifiar 1 🕒 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 \$ 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 21776 Meleds. My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

SURYA MWDRA ND 8109 RICHE HWY PAJAI) END MO 2/122 MUNDRA NO

State Registrar

DHMH 16 Ray 6/95

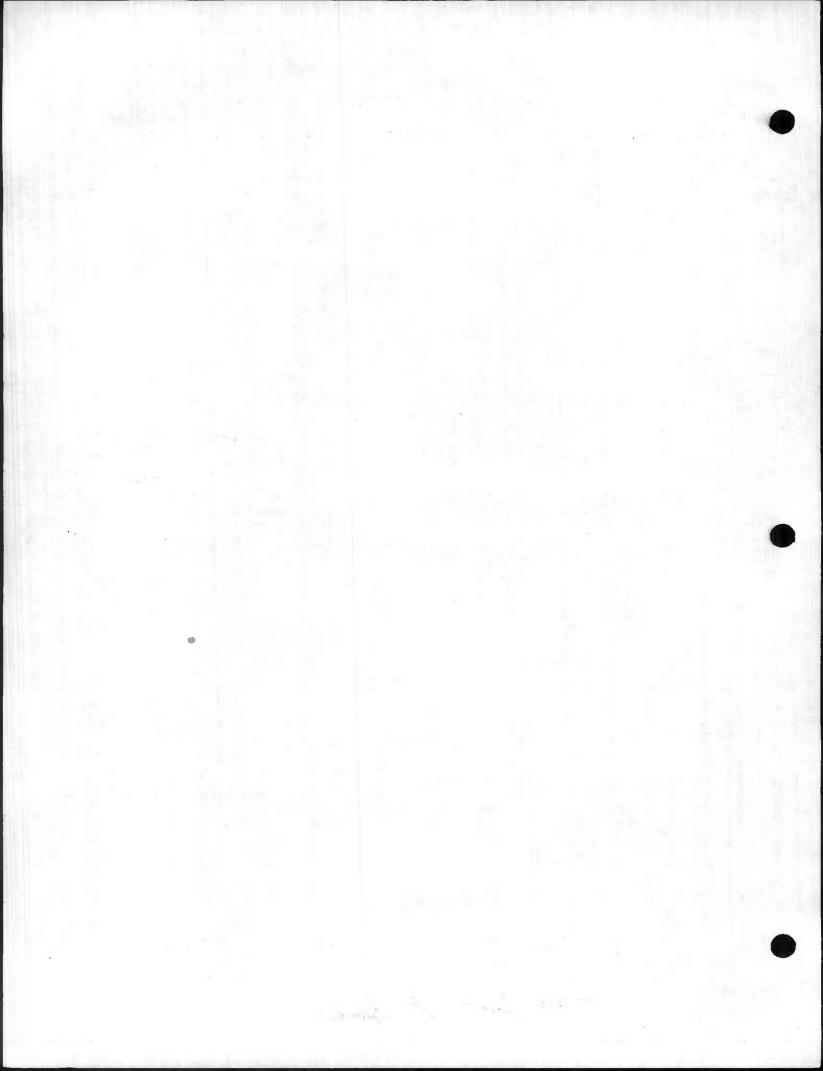
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Records.

Division of Vitai

L°2'7"1999

32 Registrar's Signature



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dey 24 Month MARY COLLEEN BOWIE 0240 07 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNIV OF MARYLAND MEDICAL SYSTEM BALTIMORE **Baltimore City** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1□M 20 F 51 217-52-4977 September 15, 1947 Virginia Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No Sykesville Maryland Carroll 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21784 U.S.A 339 Kingston Circle 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No it Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried 1□ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Restaurant Elementary/Secondary (0-12) College (1-4or 5+) Bartender 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name /First, Middle, Maiden Sumemel Betty Rousselle Richard R. Dusablon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 339 Kingston Circle Sykesville, Maryland 21784 Mr. Walter L. Bowie Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 07/27/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licenses 22. Neme and Address of Facility Slack Funeral Home, P.A M00535 3871 Old Columbia Pike Ellicott City, MD 21043 ME ent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head feliare. List only one cause on each line. Approximate Intervat Between Onset and Deeth mediete Cause (Finel immediate Cause (r disease or condition resulting in death) ZMOS IDIOPATHIC PULMONARY FIBROSIS Due to (or as a consequence of) Due to (or as a consequence of). Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Department of Important: If any Injury or

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

Completed by

Be

Funeral

Director

r than "natural", or items 23a or 28a-f ahov the Wedical Examiner must be notified at

death with the Manyland

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than ' ury or other traumatic event, the Ma

21215-0020

aitimore, Maryland

The law requires that the death certificate be executed P.O. Box 68760, physician s the burial ed by Division of Vital Records. should be o page 2 certificate Hospital or Attending Physicien: funeral director, this After

after death.

Director: Aft

To the Hospital within 24 hours a To the Funeral D completaly filled

filled in by

Physician/Medical Examiner

by

Completed

Be

edical Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medicat

29b. Signeture and title of certifier

1 Yes 2 No

27. Menner of Death

1 Netural

2 Accident

3 Sulcide

29e. Certifier

4 Homicide

24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

1 ☐ Yes 2 KNo 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

07/26/99

154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Hospitel:

1 Mnpatient

28a. Dete of Injury (Month, Day Year)

22 S. GREENE ST BALTIMORE, MD

#12429

State Registrar

31. Date filed (Month, Bay, Year)

JEAHAN R HANNA, MD

5 Pending investigation

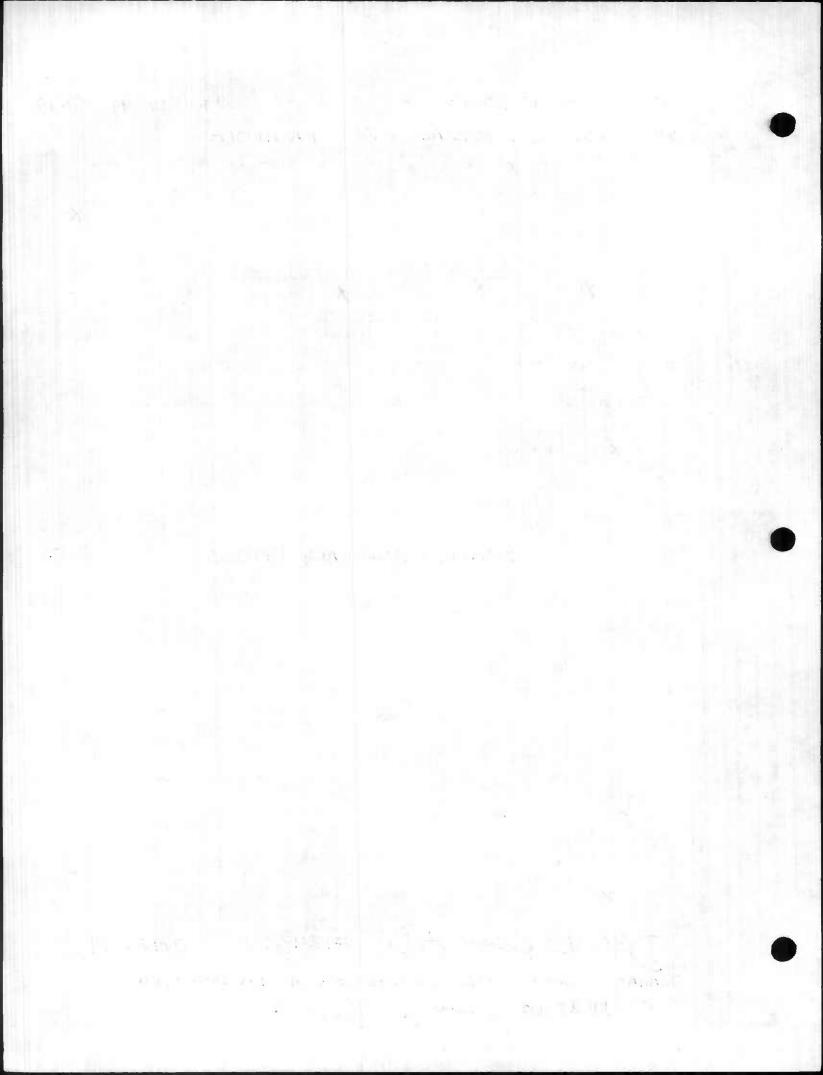
6 Could not be determined

32. Registrar's Signeture

2 ER/Outpatient 3 DOA

28b. Time of

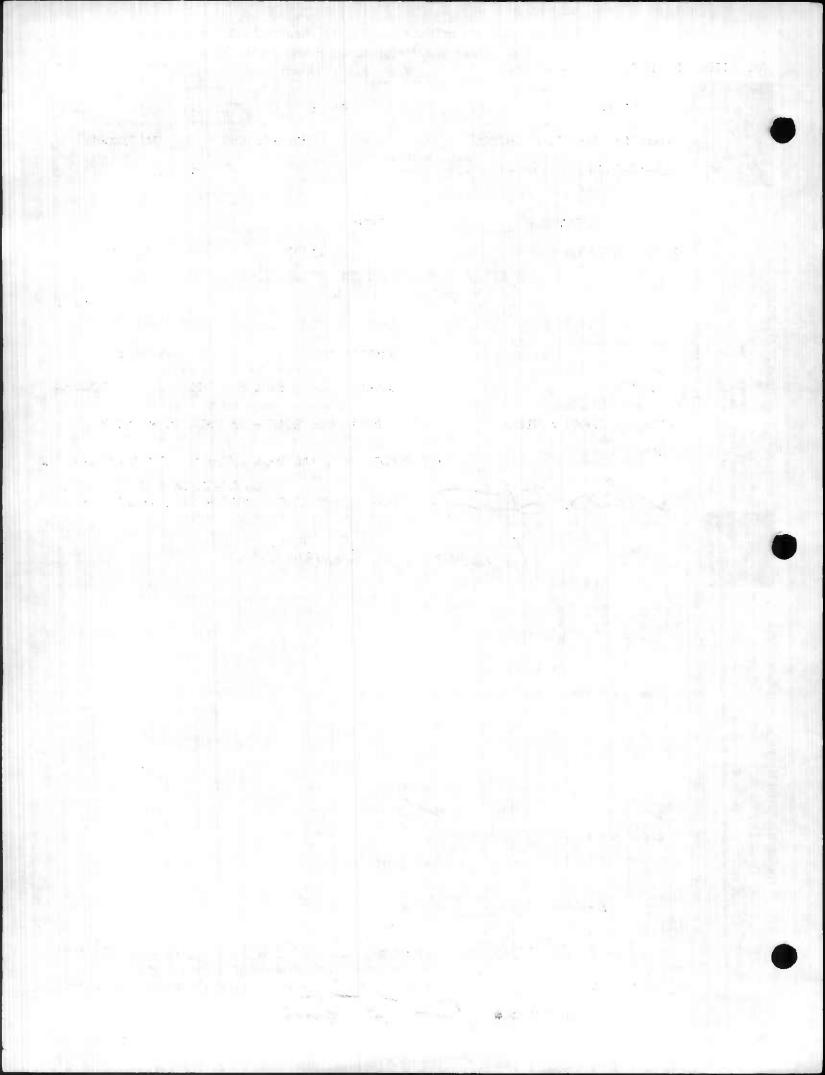
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



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lan	2 should be filed within and Mental Hygiene. Is marked other than aumetic event, the M	To Be	Horace Smith	Charles				Winn		beth Fo	•	
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	of Health Item 27		Patricia S. Vol	ker (dau	ghter)		ingston		Baltimore	-		
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation		Siale		sition (Neme of natory or other ple		Date	20c. Location -		
altir	그들루를		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funerel Sarvice I		Gre		nt Crema . Nama and Addre		1-21-99	Baltimo	re, m	aryland
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68760,	cate be executed physician and the burial-transit	dical	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or	as a consequ	uence of):					
	the death certificate be executed y the attending physician and Iched for use as the bural-transit	Med	rosuling in deality Last	d								
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Ö	5 분 등 등	Cert	4 ☐ HomicIde Gatarrii	buildir	ng, atc. (Spacify,)	,,		City or 1	own, State)		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	Check only 2 Medical E	Physician: To tha Examiner: On the ba	isis of axaminati	vledge, deeth lon and/or inv	occurred at tha ti	ma, data and opinion, daath	placa, and dua to the occurred at tha time	e ceusa(s) end ma e, date and plece,	annar as ste	ited. tha cause(s)
	of the	Mec	one) 29b. Signature and tiple of certifier	and manr	nar steted.		29c. Lican	sa number		29d. Dete signe	d (Month, D	ley, Year)
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	Sta Registr		31. Dete tiled (Month, Day, Year)	1999	egistrar's Signat	G.	Look	1				



AMEND ITEM:	#18 PER F.H. G774 8-9	State of N 9-99 WR.	Maryland / De C	partment of I ertificate of		Reg	ene 9 2	3569
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Examiner	4e Facility Neme (If not institution, NORTHWEST HOSPI				4b. City, Town, o	r Location of Deeth STOWN	4c. County of Deat BALTIMO	
Funeral Director	5. Social Security Number 217–40–0404	5. Sex 1 2 M 2 □ F	Age (In yrs. last birthda 56 Yrs.	Months Deys	If Under 24 Hr Hours Mir		(ear) 9. Birt 1942	hplece (Stete or Foreign buntry) MD
n the Maryland r 28a-f show tractified a	Usuel Residence of Decedent 10a. Stete 10b. County MD BALTI	MORE	10c. City, Town or	Location TIMORE				10d. Inside City Limits 1 ☐ Yes 2 🏋 No
ath with the Mar 23e or 28e-f si cet to morthour	10e. Street end Number 3813 BRENTFORD	ROAD		10f. Zip Code	21133	109	g. Citizen of What Co U.S.A	
020 urs effer death v if, or items 23 team v tm team v	11. Meritei Status 1 Never Merried 2 Merrie 3 Widowed 4 Divorced	12. Wes Decede Armed Force d 1 XYes 2 If Yes, Give Year or Dete	NATL GRD	3. Was Decedent of I If Yes, specify Cub		Specify Yes or No- rto Ricen, etc.)	14. Race - Ame Bieck, White Specify:	
Maryland 21215-0020 d 2 should be filed within 72 hours efter death with the Maryland th end Mental Hygiene. 7 Is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Essiri set must be incolled as the medic event, the Medical Essiri set must be incolled as	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	Education	16e. De (Gi life	cedent's Usuei Occup ve kind of work done b. DO NOT use retire	during most of w d)	orking	Sb. Kind of Business/	
aryland 2 should be filed and Mental Hygie be marked other umatic event, I	17. Father's Neme (First, Middle, La GERALD			BANKS	1	ame (First, Middle, Me	eiden Sumeme)	ICHMAN_
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Baltimo permit. Page: Department of Important: If is any injury or page.	21. Signeture of Funciel Service Li	censee		22. Name end Address	S	OL LEVINSO ROAD - PI		
Physician /Medical Examiner	23e. Pert1. Enter the disease, or c shock, or heert feilure. List of limmediete Cause (Finei disease or condition resulting in deeth)		on line. Due to (or as e confi	y En			et,	Approximate Interval Between Onset and Deeth
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t dis by	examiner 1 Des 2 No 27. Menner Deeth 1 Desturei 5 Pending			e of 28c. Inju		Home 5 Resider		ocify)
Division of Division of Standard Pragatory After the Individual Divector: After the Individual Division of Certification:	2 Accident investige 3 Suicide 6 Could no 4 Homicide determin	t bo	injury - At home, ferm, etc. (Specify)			28f. Location (Stre City or Town,	eet end Number or R Stete)	urel Route Number,
DIVI To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29e. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the be- caminer: On the basis end menner	st of my knowledge, de of exemination and/or stated.	eath occurred et the t investigation, in my	ime, dete end pie opinion, deeth oc	ce, end due to the car curred et the time, del	use(s) end menner a te and piace, and du	s stated. e to the cause(s)
To the within To the comp	29b. Signature end title of certifier	IF DA	Quael	29c Licen	se number - 0 9 3 8	29	d. Oate signed (Monte	th, Day, Year)
15+1	30. Name and address of parson w	ho completed seuse of	d deeth (item 23e) (Tyr	oe, Print)	1/Han Balt.	nlet An	1/ 8/ 2	210
State Registrar	31. Dete filed (Month, Day, Year)	32. Regi	strat's Signature	B. 4	rack			



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Realth and Mental Hygiene Certificate of Death 1, Decedant's Name (First, Middle, Last) 2. Dete of Deeth 23, EUNICE N. BEANE JULY 1999 2:45 PM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | Months | Days | Hours | Min. | 0 9 / 0 9 / 1 9 0 6 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign 1 □ M 2 KF OHIO 92 212-20-4731 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 250 No BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 SOUTHERLY RD 21204 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ₺ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 + SOCIAL WORKER SOCIAL WORK 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) ROBERT P. TAYLOR MYFANYWY MORGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS JACKSON (STEP DAUGHTER) 413 ROCKFLEET RD. TIMONIUM, MD. 21093. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriei 2 ☐ Cremation 3 ☐ Removel from Stete GREEN MOUNT CREMATORY 07/26/99 BALTO., MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Servica Licensee 22. Name and Address of Fecility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or hear failure. List only one cause on each line. Approximata tnterval Between Onset and Death CONGESTIVE HEART FAILURE Immedieta Cause (Final disease or condition resulting In death) 5 DAYS Dua to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION 5 DAYS Dua to (or as a consequenca of): Due to (or as e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes an eutopsy performed?

Physician /Medical Examiner

and

Physician

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7 is marked other than "natural", or items 23s or 28s-f sho traumstic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within Department of Heelth end Mental Hygiene. Important; if Item 27 is marked other than "I any injury or other traumetic event, the Med

with the Marylend

death

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceusa (Disease or injury that initiated events resulting in death) Lest Physician/Medical

PNEUMONIA by 24b. Were eutopsy findings availeble prior to completion of cause of deeth? Completed URINARY TRACT INFECTION 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case raferred to medical examiner? Be 26. Piece of Deeth (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpetient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Panding investigation Naturet 2 Accident 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be datermined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, factory, offica building, atc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Cartifier

29c. License number

D16492

29d. Date signed (Month, Dey, Year)

burial-transit P.O. Box 68760. 2 the 98 etten Por signed by the el d be detached for Records, page 2 hes After this certificate Division of Vital Hospital or Attanding Physician: 24 hours efter death. ofter death. To the Hospital within 24 hours e To the Funeral C

> State Registrar

31. Dete filed (Month, Dey, Year)

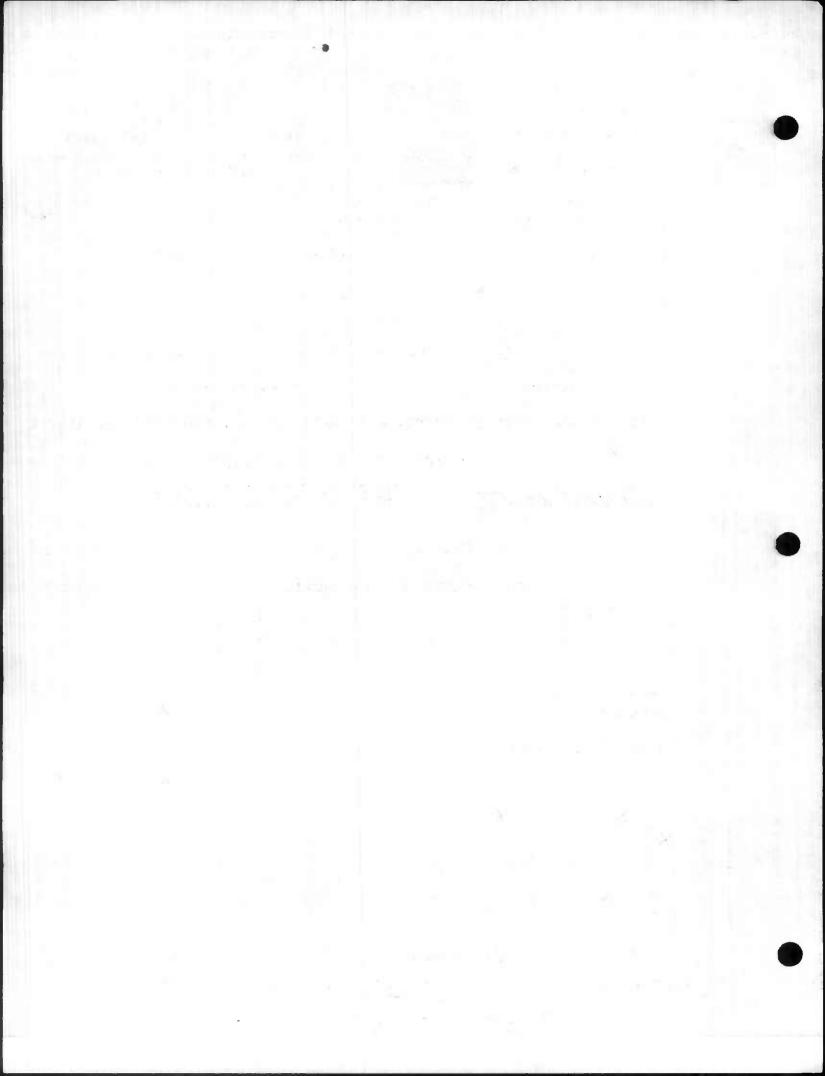
30. Neme end eddress of parson who completed causa of darth (Item 23e) (Type, Print)

DIZON,

29b. Signeture end title of certifier

BEATRIZ P.

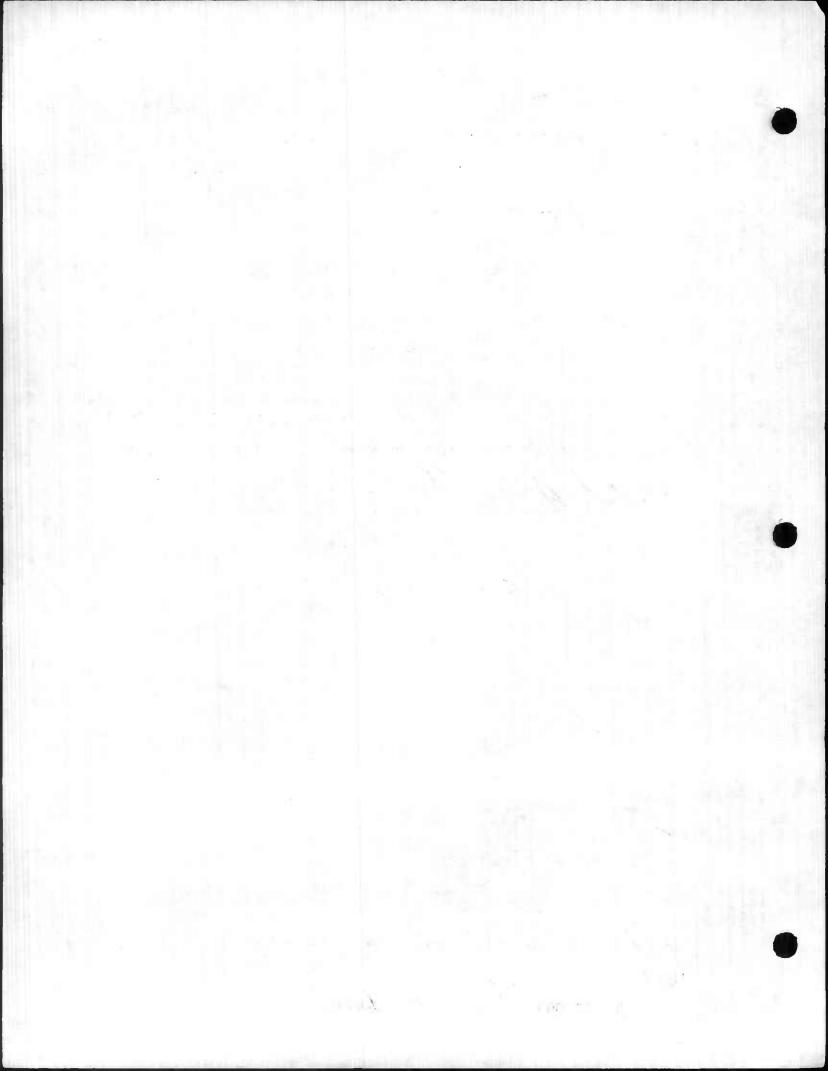




State of Maryland / Department of Health and Mental Hygiene 23571

			Certificate of Death	Reg. No.	20011			
	Physiciar			2. Date of Death Month Day Ye. July 23, 1999				
	/Medica Examine	4. English Name /// not institution who stoned and sumbout	4b. City, Town, or L					
7	Examine	Crofton Convalescent Center	Crofton	Anne Ai				
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last. 030–07–8078 1□ M 2√ F 86		8. Dete of Birth (Month, Day, Year) 9. Aug. 24, 1912 Ma	Birthplace (State or Foreign Country) ASSAChusetts			
	D	Usual Residence of Decedent						
	anylar din		own or Location		10d. Inside City Limita			
	N and a second	rib Ailie Arunder Cro	wnsville	1 □ Yes XC				
	ifer death with the Mar r Name 23e or 28e-f st river mant be notified	100. Street and Number 1007 Joyce Drive	10f. Zip Code 21032	10g. Citizen of What USA	t Country?			
Maryland 21215-0020	L's	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Splif Yes, apecify Cuban, Mexican, Puerto 1 ☐ Yes 2\text{\text{XNo}} Specify:	pecify Yes or No- D Rican, etc.) 14. Race - A Black, W Specify:	American Indian, Yhite, etc. White			
5-0	ed within 72 hours ygiene. Nor then "natural", It, the Medical Ex	15. Decedent's Education (Specify only highest grade completed)	Ba. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Busine	ess/Industry			
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anc	2502 0			de Bailey				
3	should be ind Mental i marked o umatic av				- T- O-4-1			
Ma	2 6 6 2	19a. Inlomant's Neme/Relationship (Type, Print) Carol Rothermel (Daughter)	9b. Mailing Address (Street and Number or Ru 1007 Joyce Drive, Cr					
Baltimore,	Pages 1 and 2 nent of Health int: if Hem 27 iny or other tri	20e Method of Disposition 20h Place	of Disposition (Name of	Date 20c. Location - City 07/26 Baltimore	or Town, State			
##	tant:	4 Donation 5 Dother (Specify)		Daitimore	=, FID			
Bal	permit. Pages Department of Important: If It any injury or once.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hardesty Funera 12 Ridgely Ave.		21401			
		23a. Part1. Enter the disease, recomplications that caused the death. D shock, or heart lailure. List only one cause on each line.			Approximate Interval Between			
	Physician /Medical Examiner		a consequence of): Parking.	on'n deseese	Onset and Death			
Box 68760,	death certificate be associted e attending physician and of or use as the burial-transit striam/Medical Examiner	Ceuse (Disease or injury that initiated events resulting in death) Last	a consequence of):	MA COGRESS	10 7102			
œ.	death e atte	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23b. Did tobecco use contrib	outs to the cause of death?			
P.0	ed by the		g in the orderlying outdo given in tall i.		Probably 4 Unknown			
Records,	aw requisite should be sho			24e. Was an autopsy performed?	4b. Were autopsy lindings available prior to completion of cause of death?			
<u>~</u>	The tage page			1 ☐ Yes 2 ☐ No	1 Yes 2 No			
Viital	certificate rector, pag	25. Was case referred to medicat	28. Place of Dea	th (Check only one)				
of V	Z op Z	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/		oma 5 Residence 6 Other (S	Specify)			
ů.	ding Ph. After thi funeral	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28a. Dete of Injury (Month, Day Year)	o. Tima of lnjury at Work?	28d. Describe how injury occurred				
Division	or Attendent inter deat Sirector: in by the	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	M 1 Yes 2 No farm, street, factory, office	28l. Location (Street and Number of City or Town, State)	or Rural Route Number,			
led.	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certiffi	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination	lge, death occurred at the time, date and place and/or investigation, in my opinion, death occur	and due to the cause(s) and manna rred at the time, date and place, and	er as stated. due to the cause(s)			
	the this makes		/ 29c. License number	29d. Date signed (M	footh Day Year)			
D	or view	29b. Signeture and title of certifier Another Services S	le my D 220		6-99			
		30. Name and address of person who completed cause of death (Item 23)	a) (Type, Print) Coolton Md	21114				
	State	31. Date filed (Month, Day, Yest) 32. Registrar's Signature	G. Sparks					

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Q 23572 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth July 23, **Physician** Betty Jane Bragg 9:30 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3521 Glenwood Road Middle River Baltimore If Under 1 Yeer | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Ane (In vrs. last birthday) 8. Date of Birth (Month, Dey, Yea **Funeral** Months 1 M XXF Days Hours Yrs. 9, 61 Oct. 1937 Maryland 220-34-7842 Director Usuel Residence of Deceden Pages 1 end 2 should be filed within 72 hours after death with the Meryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural; or items 23s or 28s-f show ary or other traumstic event, the Medical Evaluation name to notified at 10a Steta 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1000 Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 3521 Glenwood Road 21220 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 20 No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritai Status Black, White, etc. Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: if Yes, Give Year or Detes: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Custodian Apartment Complex 9 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Moser Lilburn Atkins Georgia M. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Neme/Reletionship (Type, Print) Phyllis E. Tiemann (niece) 3521 Glenwood Road, Baltimore, Maryland 21220 20b. Plece of Disposition (Neme of cemetery, cremetery or other piece) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 Burial 2 remation 3 Removel from State 4 Donetion 5 Other (Specify) 7/24/99 Baltimore, Maryland Green Mount Crematory 21. Signature of Fun rei Service Licensee 22. Name end Address of Fecility Bruzdziński Funeral Home, P.A. elson 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical immediate Cause (Finel COPD diseese or condition rasulting in deeth) Examiner Due to (or es a consequance of): Examiner physician and s the burial-transit that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Ceuse (Disease or Injury that initiated events resuiting in death) Lest Due to (or es a consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): 88 950 ŏ 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ The lew requires 24b. Were autopsy findings available prior to completion of cause of death? been si 24e. Wes en eutopsy Completed s certificate has b t □ Yee PYNo 1 Yes 2 No Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 1 Yes 200 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 8 □Other (Specify) this funeral 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Certification: After injury 1 Maturei 5 Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be detarmined 3 Suicide 28e. Pieca of injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 28127 7-23-99 30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print) 5601 Loch Raven Blud Baltimore Md 21239

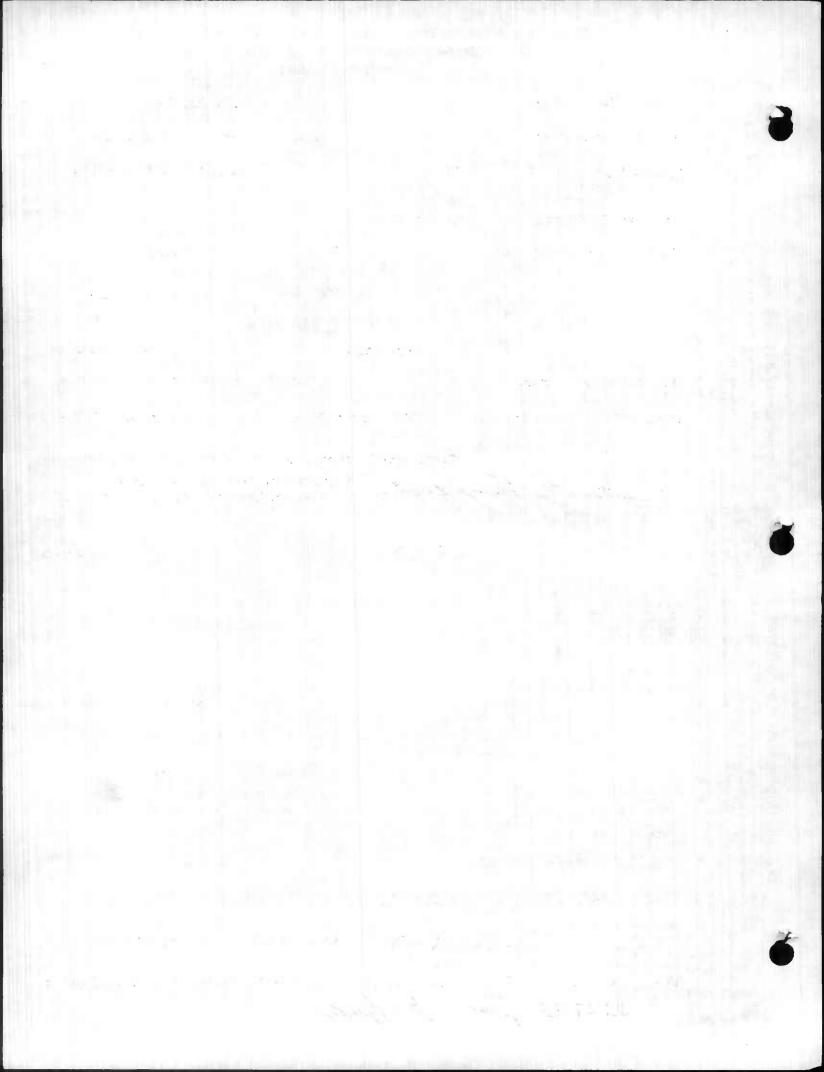
State Registrar Howard S Freeland

31. Dete filed (Month, Dey, Year)

JUL 27 1999

mg

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Dey **Physician** 05 Am Mary B. Crooks July 24 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17 Hickory Meadow Road Cockeysville Baltimore 5. Social Security Number 8. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Months Hours Yrs. Director 052-24-7800 69 Dec. 28 1929 New Jersey **Usual Residence of Deceden** with the Maryland 10a. Stete 10b. County 10c. City. Town or Location r 28a-f show 10d. Inside City Limits MD 1 ☐ Yes 2 No Baltimore Funeral Director Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural", or items 23a or item injury or other traumatic event, the Medical Examiner must be none. 21030 USA 17 Hickory Meadow Road 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis X. McKeone Mae McGarth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Gordon L. Crooks, II 17 Hickory Meadow Rd., Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ➡ Burlal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Druid Ridge Cemetery 7/27/99 Pikesville, MD 22. Name and Address of Facility
Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 Michael Flagle 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) years Examiner Examiner the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) US6 25 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 25€No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 Yes 1 ☐ Yes 2 ☐ No certificate al or Attending Physician: T s after death. I Director: After this certifical funeral director. 25. Was casa reterred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 1 Accident 5 Pending investigation 1 Yas the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide

م Division of Vital Records, Hospital
 24 hours a
 Funeral C

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State Registrar

To the To the To the

31. Date tiled (Month, Day, Year) JUL 27 1999

Paul Celano, M.D.

29b. Signature and title of certific

29a, Certifier

32. Registrar's Signature

ward, no 30. Name end address of person who completed cause of death (ttem 23a) (Type, Print)

> 6569 N. Charles St., Towson, MD 21204

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

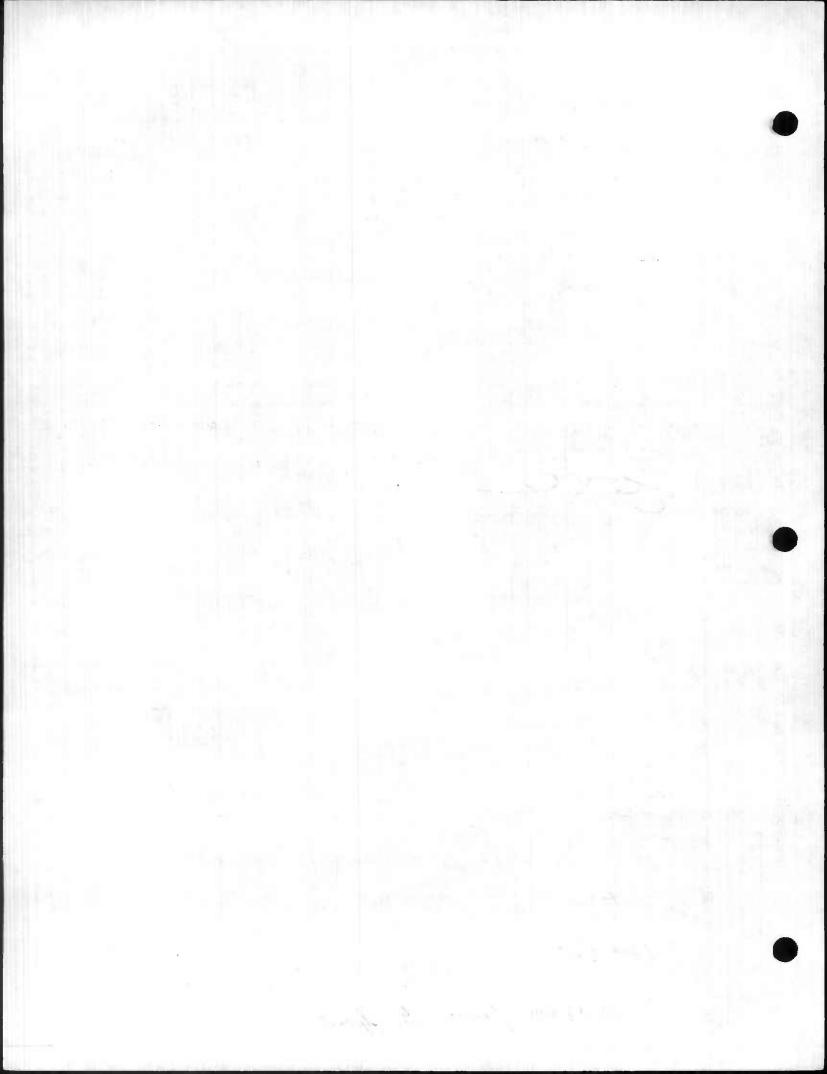
Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) and menner stated.

Suite

205

29c. License number

29d. Dete signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3574 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month **Physician** SIBBIE C ROSBY 15 A9 22 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BAltimore SAMACITON 405 If Under 24 Hrs. 8. 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 20 F Hours 14-26-6038 Director Usuel Residence of Deceden death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Mi Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 2628 Funeral 12. Was Decedent Ever in U,S.
Amed Forces?
1 Yes 20 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after t. Department of Health and Mental Hypigene. Important: If Item 27 is marked other than "natural", or then any injury or other traumatic avant Bleck, White, atc 1 Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No BIA Specify þ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coffege (1-4or 5+) WORK 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be EMMA DONIS 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) Baltimore 2628 C.

20b. Place of Disposition (Name of cemetery, cremetory or other p Biddle MD. 5/ MAYtiela AURY 20c. Location City or Town, Stete 20a. Method of Disposition

1 Burial 2 Cremetion 3 Removet from State Date Baltinore, Zion 4 □ Donation 5 □ Other (Specify) Cemetery 22. Name end Address of Facility 21. Signature of Funeral Service Licensee funeral 1129 N. CAroline Baltimore, 11D. 21213 5 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner attending physician and for use as the burle-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): signed by the a Pert tt. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ØUnknown 1 ☐ Yaa 2 ☐ No þ Completed 24b. Wera autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? has page 2 1 Yes 2 00 No 1 Yas 20 No certificata 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) 2 ER/Outpatient 3□ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient this funerai 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: is or Attending F s after death. If Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide 24 hours Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier Medical completaly (Check only one) within 2. To the 29c. License number, 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 22 no D3066 Renoneu 1

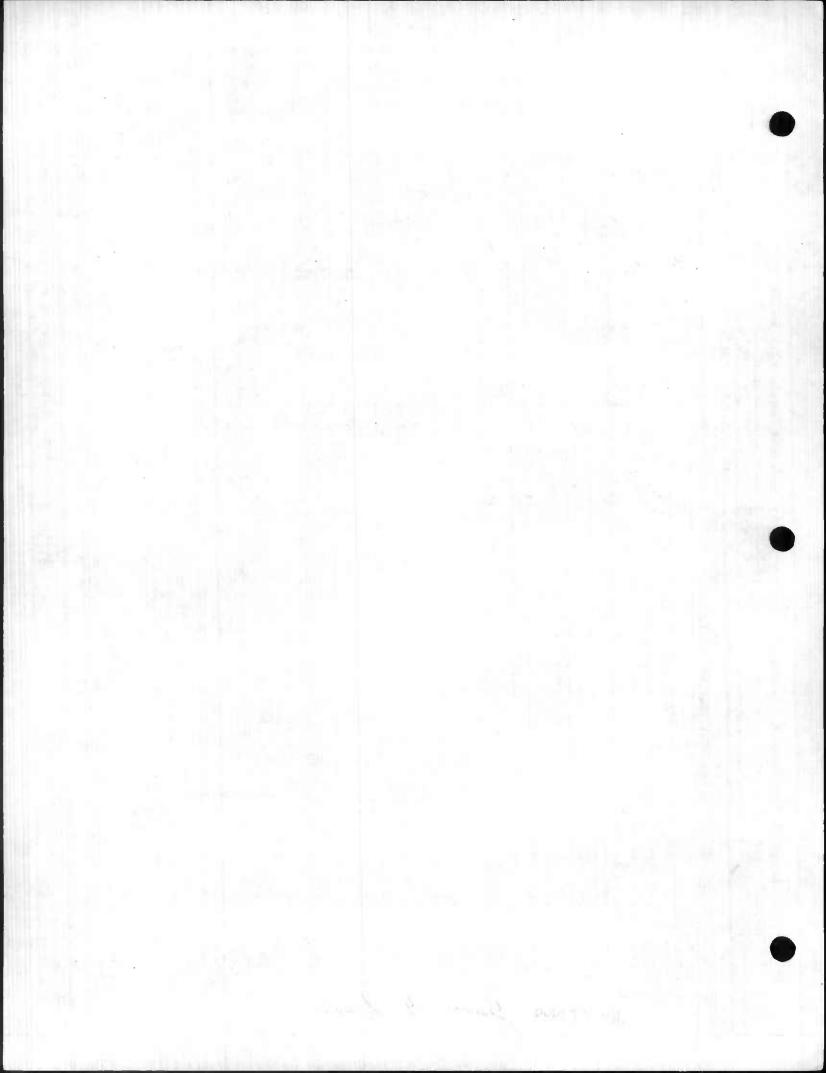
State Registrar

5601 doch 31. Date filed (Month, Day, Year)

JUL 27 1999

Prim BIREESH TRIPUR's Baltimore: Ed - 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560 (2000) Rolling Blood, 13. Blod, 32. Registrar'a Signature

MNENI



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23575 Certificate of Death 2. Date of Death 3. Time of Death **Physician** /Medical 4b. City, Town, or Location of Death County of Death **Examiner** mo 000 lawn If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day) 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 10 M 20 F Director Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 28a-f show must be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code itema 23a or 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: lack 1 Never Married 2 Married 1 Yes 2010 Baltimore, Maryland 21215-0020 8 Specify py 3 D Widowed 4 □ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: if hem 27 is marked other tha any Injury or other traumatic event, ITMAL DRGS. 12 17. Father's Neme (First, Middle, Last) Mother's Name (First, Middle, Be Barne 2 al Route Number, City or Town, State, Zio Code) 19a. Informant's Name/Relationship (Type, Print) Woy 1 onn a 20b. Place of Disposition (Name of 20a. Method of Disposition

1 Burial 2 © Cremation 3 Removal from State 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service License THE PROPERTY OF PASS

the mode of dying, such as cardiac or respiratory arrest mo 21229 Part I neer the disease, or complications that caused the death. Do not enter speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** months /Medical Immediate Cause (Finel ancer disease or condition resulting in deeth) Examiner be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last and Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown penerative disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen page 2 s certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

JUL 2 7

1999

S. Friedmen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

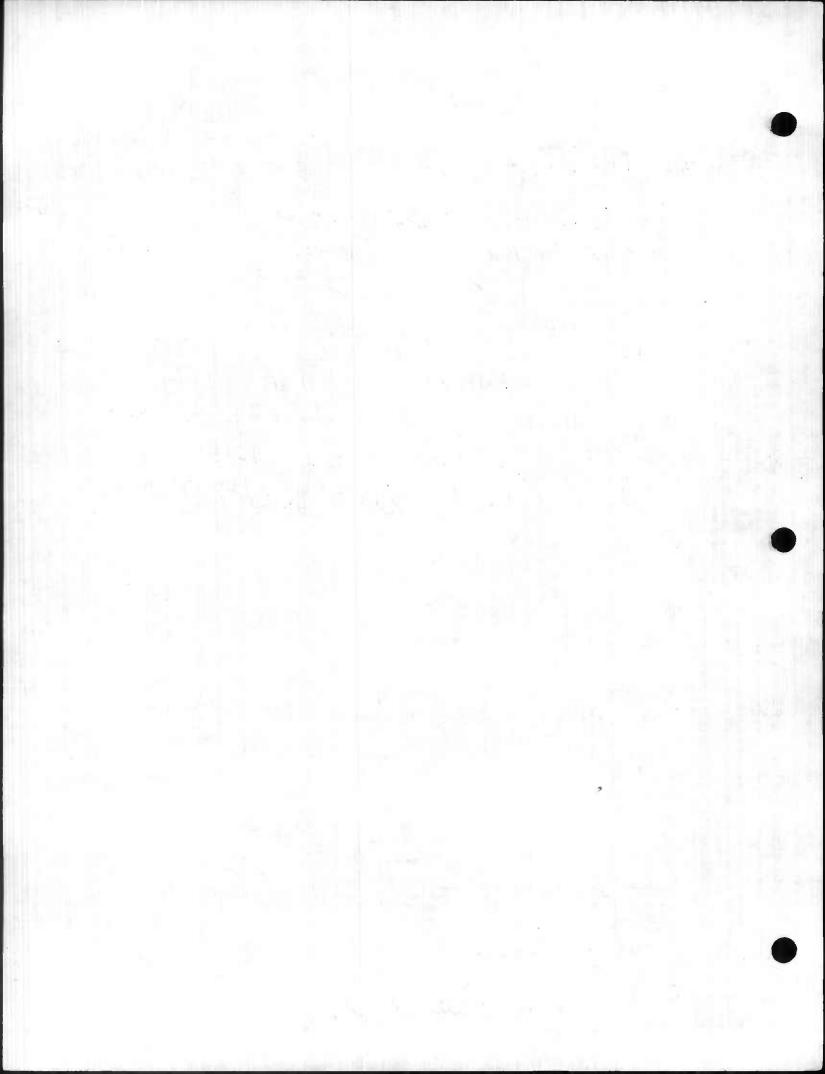
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32. Registrar's Signature

1838

Greenetree Str. 120

Baltinura, MO 21208



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Q Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month 1999 GU AM 4e Facility Neme (If no institution, give street and number) MAIN Sul 26 4b. City, Town, or Location of Deeth 4c. County of Death neclic N/A If Under 24 Hrs. 216 more NOLC 2 If Under 1 Yeer 7. Age (In yrs. last birthday) 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) 9. Birthplece (State or Foreign 1□M 2**X**F Months Deys Hours Min. 61 Yrs JULY 11, 1938 GERMANY 217-52-4227 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No ANNE ARUNDEL LINTHICUM MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 309 REGENCY CIRCLE 21090 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No It Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: WHITE 3 ☐ Widowed 4 Divorced 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR CUP MANUFACTURING CO. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) ERNST FISCHER ILSE **JAHRIG** 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JESSE E. CUMMINGHAM (SON) 518 RITA DRIVE, ODENTON, MARYLAND 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete CHESAPEAKE CREMATORY LLC.7/27/99 STEVENSVILLE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 21. Sign re of Eun Service Licensee 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 an 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediete Cause (Finel diseese or condition resulting In deeth) Due to (or es e consequence ot): Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of) thet initiated events resulting In death) Lest Due to (or es a consequence ot): 23b. Did tobacco use contribute to the ceuse of death? Pert II. Other elanificant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 2KINO 1 ☐ Yes 25 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ⊠Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation Neturel

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Med cal Examinet must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or iten any injury or other traumatic avent, the Medical Example

Baltimore, Maryland 21215-0020

the Meryland

death

Examiner Physician/Medical 980 p Completed Be 2 Certification:

physician and the burial-transit that the death certificate be executed signed by the a peen hes Division of Vital funeral director this or Attending Piater death.

> State Registrar

edicai

TO 31. Dete filed (Month, Day, Year)

MD 30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

6 Could not be determined

2 Accident

29b. Signature and title of certifie

3 Suicide

29e. Certifier

32. Registrer's Signature

28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1🔁 Certifying Physicien: To the best ot my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

2 No

Lecuson

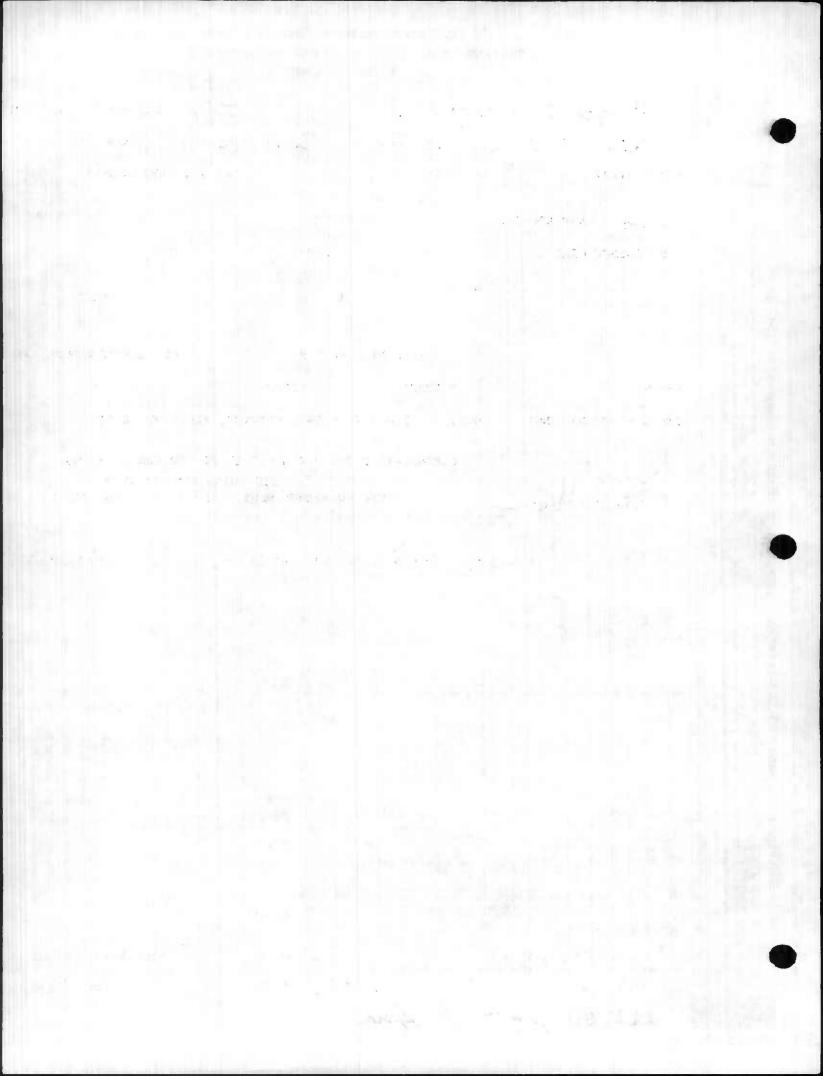
1 Yes

JUL 27 1999

DHMH 16 Rev 6/95

24 hours Hospital

To the To the To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth Month 3 Time of Death Cuffie **Physician** ElIZABETH CARRIE uli 03 /Medical 4b. City, Town, or Location of Death 4p Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Maryland Da Himor If Under 24 Hrs. 8. Date of Birth (Month, Day) If Undar 1 Yaar 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□M 200F Deys 83 Director Arolina Usuel Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at TEVes 2 No BALHIMOVE Director Mary 100 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code waldow 21215 USB 2801 Funeral Wes Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Wes Decedent Ever In U,S. Armed Forces? Race - American Indian, Bleck, White, atc. 11 Maritel Stetus 1 Yes 25 No If Yas, Give Yaer or Detes: 1 ☐ Never Merried 2 ☐ Married Specify: Black 1 Yes 2 No Specify: à 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade complated) Harylono General permit. Pages 1 end 2 should be filed within 7 Department of Heelth and Mantal Hyglene. Important: if item 27 is marked other than "any injury or other traumatic event, tra Mad page. Elamantary/Secondary (0-12) Coilege (1-4or 5+) DIEHLIMN grade 17. Fathar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Lottie Stanley PriteHET7 VAMES 19b. Melling Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informent's Neme/Raiationship (Type, Print) 1 RAIS Clark LEXINATIN STREET 2401 BALTIMONE, Med 20b. Piece of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20e. Method of Disposition Burial 2 Cramation 3 Removal from Stata Brookly CEDAY HIL 4 ☐ Donation 5 ☐ Other (Specify) noten 22. Nama and Address of Facility CHATHEN - HARKITS 21, Signeture of Funerel Service Ligursee 5240 RUS BOHHUKE REISTERROUND RUND 21215 23a. Pert1. Inter the lisesse, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shoot, or hear fellure. List only one cause on each line. Approximata Interval Batwean Onset and Death **Physician** /Medical Immediate Ceuse (Final eumonia disaese or condition resulting in daeth) **Examiner** Examiner Sequantially list conditions, if eny, laeding to immadiate cause. Enter Underlying Ceusa (Disaasa or injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Dua to (or as a consequence of) 23h. Did tobacco use contribute to the cause of coath? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 4 Unknown 1 Yes 2 No 3 Probably by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? t Vas 212No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 1 Y95 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Dete of injury (Month, Day Year) 27. Mennar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Neturel 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

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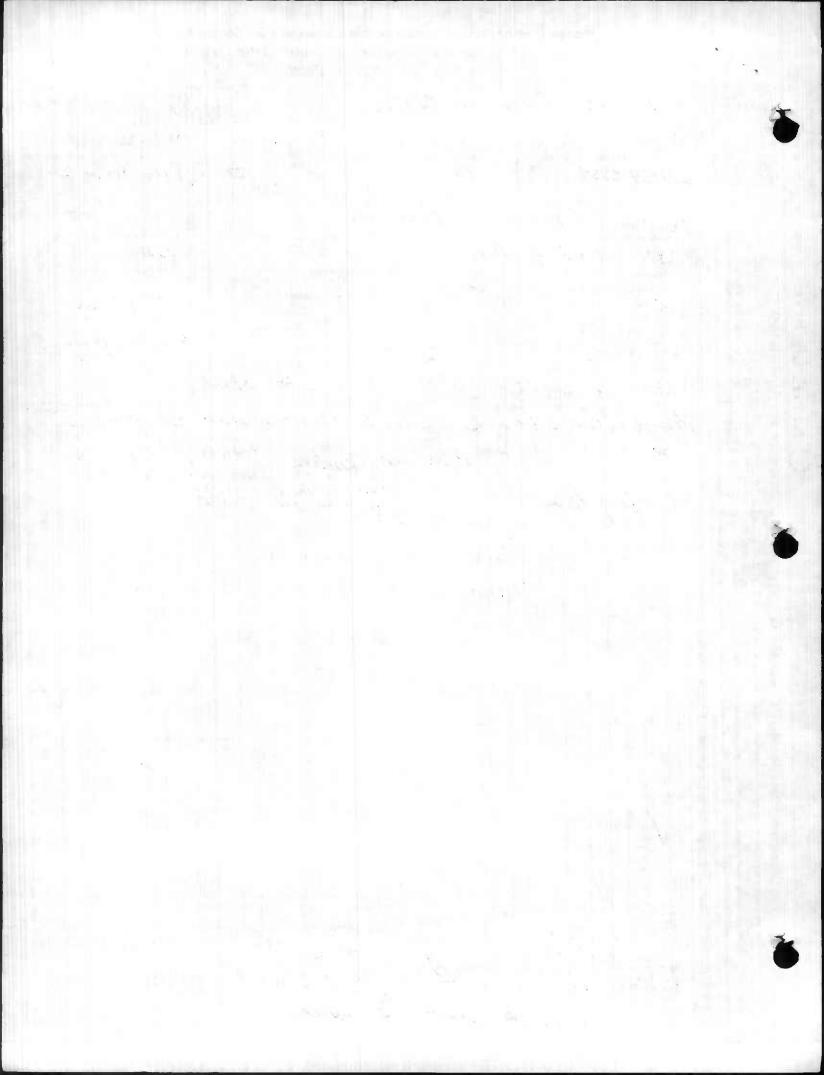
"naturel", or items

the 88 USB signed by t or Attending Physicien: after deeth. Director: Aft 24 hours a Hospital within 2 To the

> State Registrar

Medical

29a. Certifier 1 🗹 Certifying Phyelcian: To tha best of my knowledga, death occurred et the time, dete end pieca, and dua to tha cause(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end pleca, and due to the cause(s) and menner stated. 29d. Data signed (Month, Day, Year) to completed cause of death (lam 23e) (Type, Print) 30. Name, and address of land 31. Dete filed (Month, Day, Year) 32. Registrar's Sig



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death July 20, MARY **SERIO** CARNAGIO 1999 6:15PM 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Ruxton Baltimore Towson If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months 1□M 2□F 219-12-6837 July 9,1908 Maryland Usuel Residence of Deceden 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1) Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 St Georges Road 21210 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus Armed Forces?

1 Yes XX No
If Yes, Give
Yeer or Detes: Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2)(1)(No Specify: ₩Widowed 4 Divorced White 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antonio Serio Rose Palmisano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 St Georges Road Baltimore, Maryland 21210 Salvatore Carnagio Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-27-99 Baltimore, Maryland New Cathedral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 eur 23a. Part1. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Urosepsis 4 mo VUN ret Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown asteo parasis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Mannar of Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yas 2 No NK 2 Accident

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla neat of Health and Mental Hygiene. Into It ferm 27 is marked other than "natural; or itema 23a or 28a-f show that or other traumatic event, the Medical Entities mant to notify at

permit. Page Department of Important: If eny injury or page.

Physician /Medical

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Medical Certification: To

3 Suicide

29a. Certifier (Check only one)

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Baltimore, Maryland

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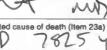
or Attending Physicien: After this funeral 24 hours after death. filled in by Hospital within 2

> State Registrar

31. Date filed (Month, Day, Year) JUL 27 1999

29b. Signeture and title of certifier

6 Could not be determined



28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

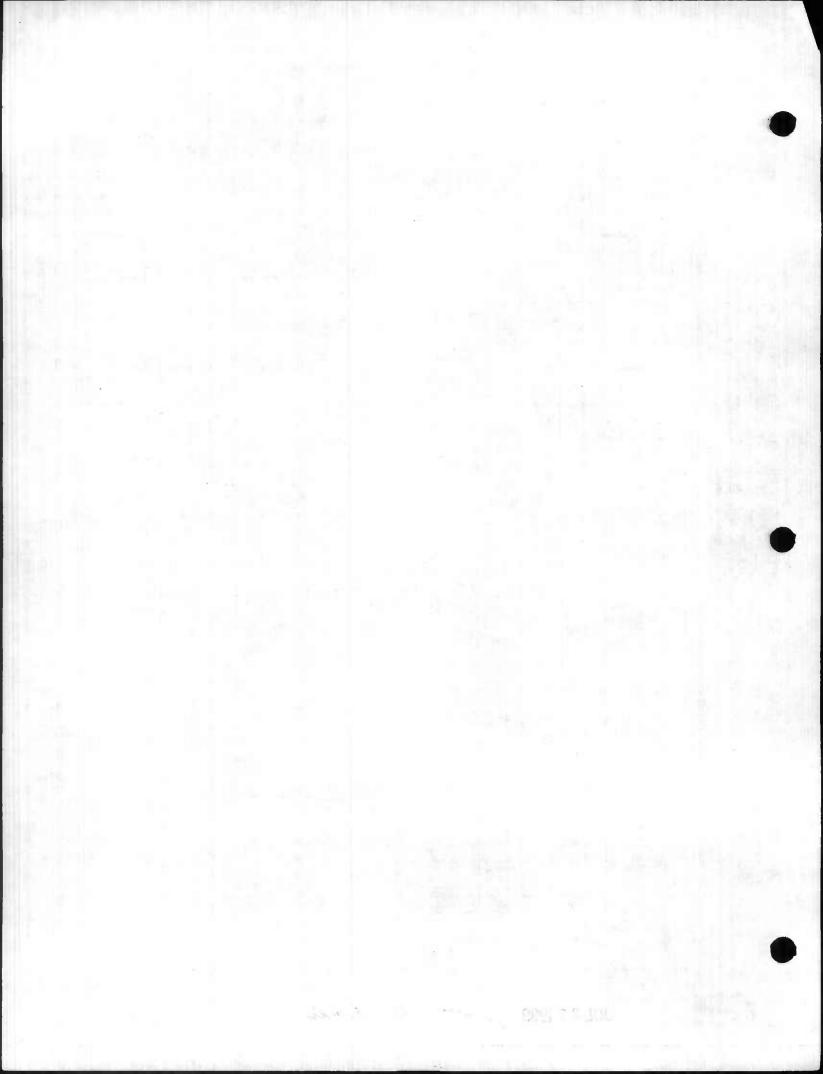
MD York 20

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

DHMH 16 Ray 6/95



Physician /Medical Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Irraportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maralcal Evantine must be notified at once.

To Be Completed by Funeral Director

Please	Type or Print State of Ma	ryland / D	Departm		Health ar		Mental Hy		9	ble. 23	3579	
Decedent's Neme (First, Middle, La GILBERT	est)			CUMMIN			2. Dete of De Month			1990	3. Time of Death 2:25 p.m -	
4e Facility Neme (If not Institution, give Sinai Hospit	1	altimore	0		4b. City, Town		ocation of Deat		County	of Deeth	6 · 20 p	
5. Social Security Number 6. S		(In yrs. last birtl		Inder 1 Year of the Deys	If Under 24		8. Dete of Bir (Month, Da NOV • 21	ay, Year)			placa (State or Foreign http://	
Usual Residence of Decedent 10a. Stete 10b. County MD N	N/A	10c. City, Town		rimore						1	0d. fnside City Limits 1XÔ Yas 2 ☐ No	
MD N 10e. Street and Number 3302 FALLSTAFF				f. Zip Code	2121!	5			zen of V	What Coun	V//	
11. Meritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:	0	If Yes,	specify Cubi	Hispanic Origin ban, Mexican, I Specify:	in? (Sp	pecify Yes or No o Rican, etc.)	0- 1	14. Raci Biec Specify	ce - Americ ck, White, W	etc. HITE	
15. Decedent's Ed (Specify only highest gra Elementery/Secondery (0-12)			(Give kind of life. DO NO	Usuel Occup of work done OT use retired PRIETO	during most o	of work	ing	16b. Kind of Business/Industry ELECTRO PLATER				
17. Father's Name (First, Middle, Last) ABRAHAM	,	С	CUMMINS	S		's Neme	e (First, Middle	, Maiden :	Sumam		ESSER	
19a. Informant's Name/Relationship (BROWNIE CUMMINS							ral Route Numb					
20a. Method of Disposition 1		20b. Place of cemeter, BETH T	y, crematory	or other place		7	Date 7/26/99			City or To		
21. Signature of Funeral Sympley Licer	nsee/		Commission			POL	LEVINS				INC. MD 21208	
23a. Part. Enter he diseese, or common about or he in failure. List only Immediate Cause (Finel diseese or condition resulting in death)	. Sepsis	S Due to (or as a c Resp	consequence oirator	e on): ry Di			or respiretory a				Approximate Intervel Between Onset and Deeth I week 3 weeks	
Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Aspira	Tron Due to (or es a co	Pneum	nonia							3 weeks	
Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlyi	ing cause giv	ven in Pert f.			1	Ves cor		o the cause of death? bably 4 Unknown	
						_		s an autop: ormed?	sy	evi co	era autopsy findings ailable prior to empletion of cause death?	
							10	Yes 20	(No	10	□Yes 2X No	
25. Was casa referred to medical axaminer? 1 Yes 2 No	Hospitel: 1 Manation	nt 2 ER/Out	tratient 3	T DOA OF	ther _		th <i>(Check only o</i>		s Cont	er /Snecil	(v)	

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner 8 Medical Certification: To

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

27. Menner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Neturai 2 Accident 5 Pending Investigation 1 Yes 2 No

6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, deta and place, and due to the cause(s) end menner steted.

29c. License number

29b. Signature and title of certifier

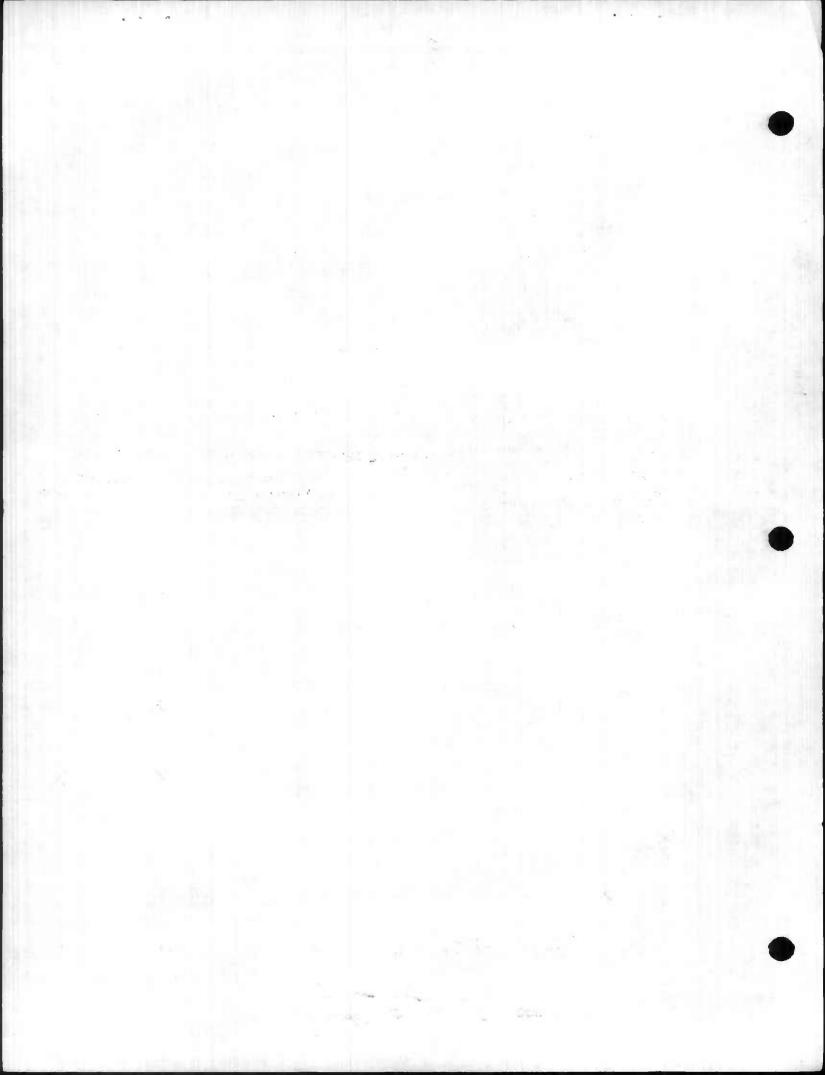
29d. Dete signed (Month, Dey, Year) 25, 1999 PAS# 08761

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai Hospital of Baltimore, Baltimore City, H.D PATRICK F ITTON 31. Date filed (Month, Day, Year) 32. Registraris Signature

State Registrar

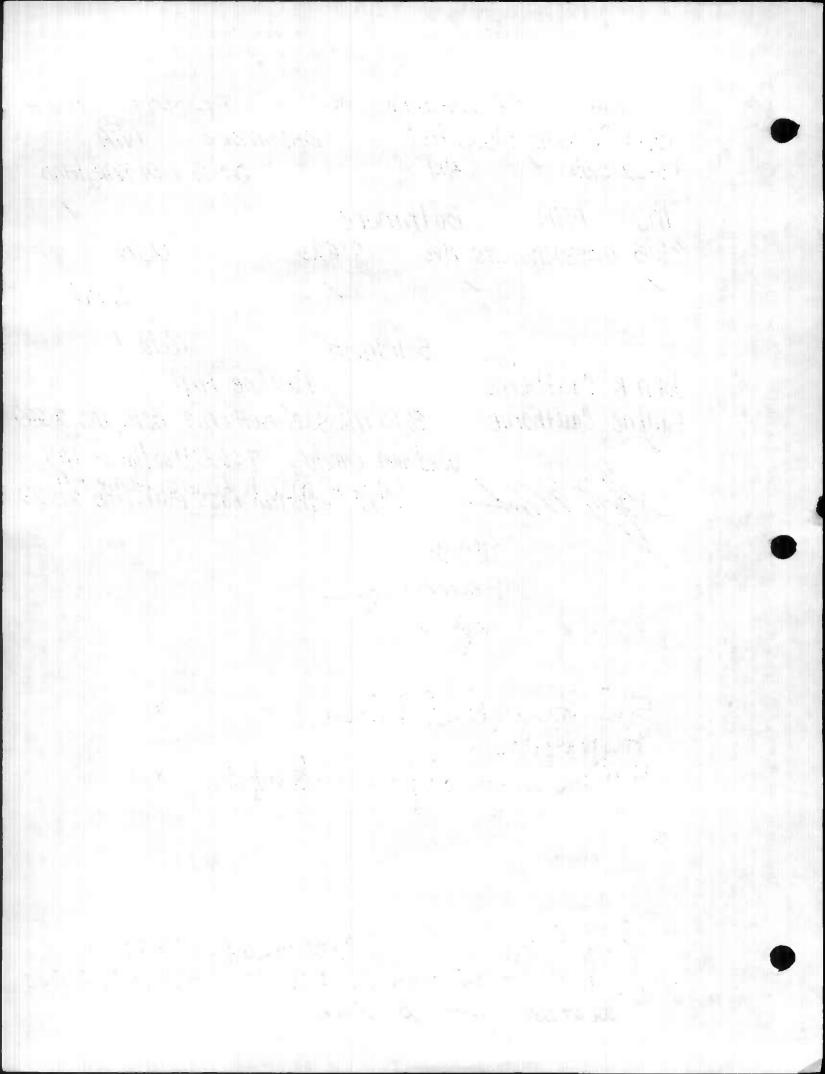
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** -99 JOHN 3:30 A /Medical 4b. City, Town, or Location of Deeth Examiner If Under 24 Hrs. If Under 1 Yeer **Funeral** Deys Months 1 M 2 F Hours Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Int: If Item 27 Is marked other than "natural", or Items 23s or 23s-f ahow any or other transmit or natural cannot be notified at any or other transmit cannot be notified at City, Town or Location 10e Stete 10d. inside City Limits 1 Yes 2 No Director 10g. Citizen of Whet Country? Funeral 12. Wes Decedent Ever in U,S Armed Forces? 1 Yes 2 UNo It Yes, Give Yeer or Detes: 14. Rece - American Indien, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

SaleSman 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (1-4or 5+) Elementary/Secondary (0-12) Mother's Name (First, Middle, Maiden Sumeme) Fether's Name (First, Middle, Last) Be Important: If item 2. any injury or other page. 20b. Plece of Disposition (Name of cametes), crematory or other 20e. Method of Disposition 1 Burlal 2 Cremetion 3 Removel from Stete 4 □ Donetion 5 □ Sther (Specify) 21. Signature of Formal Service Licensee The mode of dying, such as cardiac or respiratory errest, or employions that caused the List only one cause on each line Approximete Interval Between Onset and Deeth ons thet caused the death. Do not enter **Physician** Immedian Cause (Final diseese or condition resulting in death) /Medical Examiner Physician/Medical Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that inflieted events resulting In death) Lest Division of Vital Records, P.O. Box 68760, ost Que to (or es e consequence of) USB as 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. been signed by the should be detach 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed After this certificate has I funeral director, page 2 s Human 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 1 Inpatient 3□ DOA 2 ER/Outpatient 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 1 Neturel 5 Pending Investigation 2 No 1 Yes within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 \(\text{Hom/cide} \) edicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of pertifier 29c. License number 30. Name and ot deeth (Item 23e) (Type, Print address of 1940 31. Date tiled /Month. Day, Year 32. Registrer's Signature State JUL 27 1999 Registrar **DHMH 16 Rev 6/95**

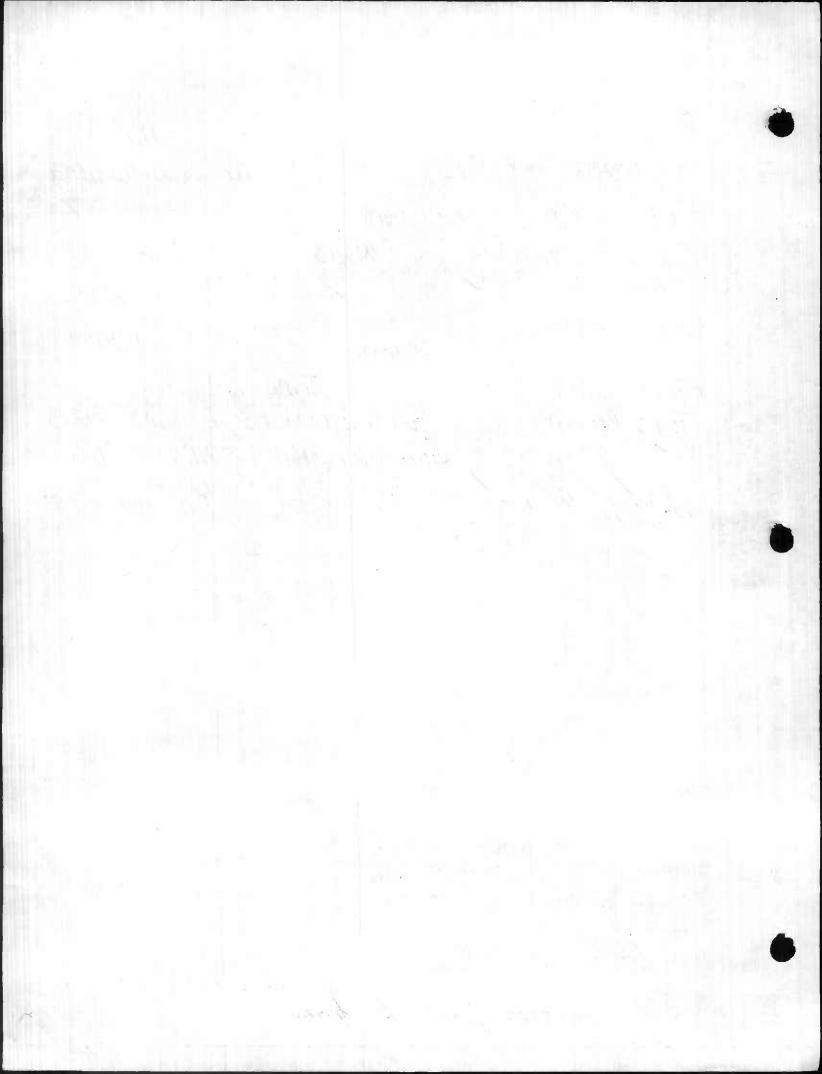


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State of Maryland / Department of Health and Mental Hygiene 9 2 3 5 8

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	Physician /Medical		ounts			2. Dete of Death Month JULY		10	na of Deeth 057 AM
Į,	Examiner	4a Facility Name (If not institution, give s UNIVERSITY HOSPI			4b. City, Town, or BALTIM	Location of Death	4c. County of De	eath	
	Funeral Director	5. Social Security Number 6. Sex	M 200 7. Age (In ye	Yrs. If Under Months	r 1 Year If Under 24 Hr Days Hours Mir			Sirthplace (Si	notete or Foreign
	e Maryland Ref show director	10a. State 10b. County	Ba City	Town or Location					de City Limits Yes 2 No
	ath with the Mar a 23a or 28e-fa mat be notified	10e. Street and Number 502 5. Bentai	lou St.	21	223		g. Citizen of What	·	
0000	within 72 hours after death with the Manyland one. than "natural", or items 23a or 28a-f ahow he Madrell Empress must be notified as named and the Figure of the Manyland of the Control o	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Wes Dec	dent of Hispanic Origin? (ority Cuban, Mexican, Pue 2 D No Specify:	specify Yes of No- rto Rican, etc.)	14. Race - Ar Black, Wi Specify:		K
21215-0020	TO SEE SEE	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usi (Give kind of w Jile. D9 NOT)	ork done during most of wo	orking	6b. Kind of Busines	I/A	
Maryland	Mental H Mental H arked oth artic avan	17. Father's Name (First, Middle, Last) Troy CountS			18. Mother's Na	REDUY	aiden Suma ne)		
	Heal Heal ther	19a. Informant's Name/Relationship, (Type Dr. Ch.) 20a. Method of Disposition		19b. Mailing Address 502 S. ace of Disposition (Na	s and Number or F 13entalou me of	St. Ba.	City or Town, State 10, M.D. 0c. Leation - City	212	
Baltlmore,	Pages nent of ant: If It ury or o	1 Burial 2 Commetton 3 Relation 3 Other (Specify) 21. Signeture of Furerel Service Uicense	emoval from State And	metery, cremetory or UTUS Mely	other place) Park	7-27-994	rbutus,	MD	
Ba	permit. Departrimportulany injugan	23a Parti Antar the Maeasa or comple	sations that caused the death	Do not enter the mo	P. March	Eune Ca Bass Ba	Home Home	2 2/3	229 ximete
	Physician /Medical Examiner	show, or heart failure. List only on Immediate Cause (Finet disease or condition resulting to death)	Gunsla		of Ches		.,	Interve	al Between and Deeth
68760,	rificate be assouted by physician and as the burial-transit	Cause (Disease or Injury that initiated events resulting In death) Last		as a consequence of					
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, P.O.	requires that the death ce even signed by the attendit hould be detached for use eted by Physician/I		inbuting to death but not resu	iting in the underlying	cause given in Pert I.	230. Did tot	s PNo 3		4 Unknown
Records,	2 2 B					24a. Was an perform		b. Were auto available p completion of death?	prior to
	ician: The law certificate has b rector, page 2 a Be Compile				00 Piers - (P	10.10	ž DNo	18 Yes	2□ No
of Vital		1X1 Yes 2 No	ospital: 1 ☐ Inpatient XX 1	ER/Outpetient 3 0	104	eath (Check only one Home 5 Resider		pecify)	12.74
	After this funeral d		28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe how		, ,	
Division	or Attendent Director: in by the	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	7/21/99 28e. Place of injury - At ho building, etc. (Specify	me, farm, street, facto	Yes 2 □ No	284 Language (Str	eet and Number or State) 2300	Buest Boute	Number,
	n 24 hours in 24 hours in 24 hours in Euneral pletely filled	29a. Certifier 1 Certifying Physic (Check only 2/ Wadical Examin	iclan: To the best of my know er: On the basis of examinati	vledge, death occurred			use(s) and manner		ura(e)
	within 24 To the Fi		and manner stated.						
	To the within To the comple	29b. Signature and title of certifier	2 Chustra	28	O.C.M.E	29	d. Date signed (Mo		
250		30. Nama and address of person who			mot Delti-	o	land 2122	1	
	State	21 Onto Blad (Month Day Your)	32. Registrar's Signat		reet, Baltim	ore, mary.	Land 2120	Τ	



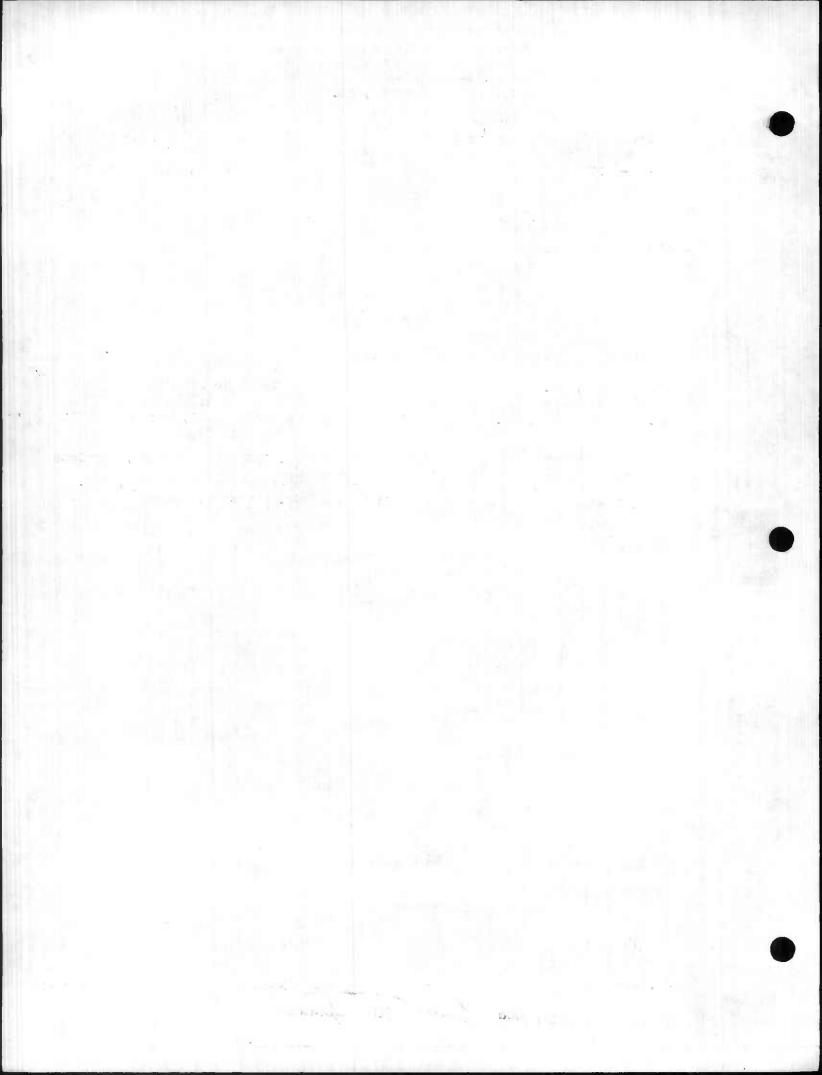
Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedani's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth COMBS, SR. RICHARD Dey Month **Physician** July 25, 1999 8:15 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Mariner Health of Glen Burnie Glen Burnie Hours Min. 8. Data of Birth (Month, Day, Year)
July 7, 1953 If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Country) Maryland 189 M 2□ F Yrs 46 Director 218-58-3017 Usual Rasidence of Decedant death with the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show me 23a or 28a-f short NO Yes 2 No Baltimore City Maryland N/A Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 United States 1340 Cambria Street Funeral 14. Rece - American Indian, Black, Whita, etc. r than "natural", or flame the Medical Examiner or 12. Was Decedant Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Maritai Siaius filed within 72 hours efter 1 Yes 28 No 1 Never Married 2 Merried 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify. þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: White Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) I Hygiene. Automobile Body Elementary/Secondary (0-12) College (1-4or 5+) Repair Repairman i. Peges 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If Item 27 is marked other talury or other traumatic svent, in 8 Years altimore, Maryland 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be Trene Demetrician Allan Combs, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son 307 Stemmers Run Road Essex, Maryland 21221 Mr. Richard Combs, Jr. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department c important: If any injury or Hilltop Service Corp. 7/28/99 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the cyclese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or raspiratory arrest, shock, or heart lettura. Use only one cause on each line. Approximete intervei Between Onset and Death **Physician** /Medical Immediata Causa (Final a. RESPIRATORY FAILUIZE

Dua to (or as a consequence of): disaasa or condition resulting in death) HOURS Examiner ADVANCED METASTATIC CARCINOMA LUNG The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediata causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical the Dua to (or as a consequence of) 60 60 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown been signed by should be detac MALIVUTRITION Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physicien: Be 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Other: 4 Nersing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how Injury occurred 28b. Tima of 28c. Injury ai Work? After 1 Naturai 5 Pending efter death. 1 ☐ Yas 2 ☐ No invastigetion 2 Accidant 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours e To the Funeral D completely filled Hospital 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mennar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifiar D0054288 30. Name and addrass of person who complated causa of death (item 23a) (Type, Print) Dr. Ramaswamy Ramgarajan 7445-A Furnace Branch Road Glen Burnie, MD 31. Data filed (Month, Day, Year) 32. Registral Signatura

DHMH 16 Ray 6/95

State Registrar



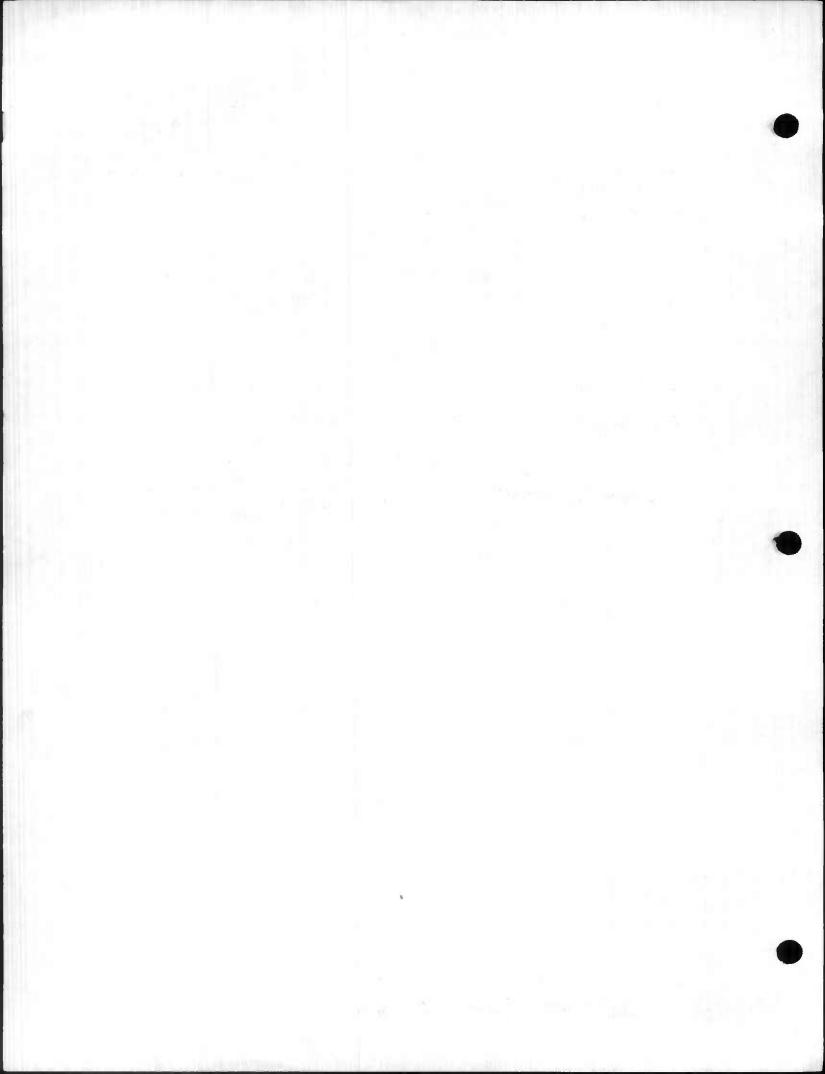
State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth July 24, 199 9 **Physician** 2:58 a.m. Emily Jane Chlebda /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Baltimore 425 Margaret Avenue Essex Hours Min. 8. Dete of Birth (Month, Dey, Year) March 7,1932 9. Birthplece (State or Fore Country) Pennsylvania 5. Sociel Security Number If Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□ м а Months Deys 193-24-5094 Yrs. Director Usuel Residence of Decedent with the Maryland 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahov Maryland Baltimore Essex 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 425 Margaret Avenue 21221 U.S.A. death 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes ② ONo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours efter of and of Health Hygiene. Int. If fam 27 Is marked other than "natural", or flee iny or other traumals event, the Magical Exercise iny or other traumals event, the Magical Exercise. 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 200No Specify: Completed by ₩idowed 4 Divorced White (e) Hygiene. d other than "natural event, the Modical E 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Assembler Bottle Manufacturer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Ersula M. Schrock Herbert J. Geary, Sr. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 425 Margaret Avenue, Baltimore, Maryland 21221 Tracy L.C. Morrison (daughter) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) permit. Pege Department of Important: If any injury or 7/27/99 Holly Hill Mem. Gardens Baltimore, Maryland 22. Name end Address of Fecility Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel CANCER BREAST disease or condition resulting in deeth) Examiner Examiner sician and buriel-transit Sequentielly list conditions, if eny, leading to immediate cause. Extra Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) physician s the buriel Box 68760, Physician/Medical Due to (or as a consequence of) 80 been signed by the etter should be deteched for a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 HO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Records. by 24b. Were eutopsy findings evelleble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 55 Residence 6 Other (Specify) 2 1 ☐ Yes 2010No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 1XX iaturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours efter deat Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide Hospital Certifying Phyalcien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical completely (Check only one) To the within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Mgnth, Dey, Yeer) 027730 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) use of Geeth (Item 23e) (Type, Print)
6569 N. CHARLET ST. BALTO AP COVEN, MO 32. Registrer's Signeture 31. Dete filed (Month, Day, Year)
JUL 27 1999 State

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMEND #11 PER F.H. G774 8-5-99 State of Maryland / Department of Health and Mental Hygiene 23584 Amended Items#20b,20c perFH G774 8/3/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** DASHNER HNER JULY
4b. City, Town, or Location of Death CONCETTA 4:30 PM 25 1999 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPITAL BALT 1 YORE SAMARITAN N/A If Under 1 Year
Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, June 23, 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1928 Hours 1□M 2XF Maryland 220-20-6511 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahom r than "natural", or items 23s or 28s-f short the Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3351 Grier Nursery Road 21154 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No if Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Heelth and Mential Hygiene. Important: if them 27 is marked other than "natural", or iten any injury or other traumetic event, the Mariel Emmin Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ø No Specify: A 3t2 vildowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
11th grade College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Joseph Venere Aurora Vitale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3351 Grier Nursery Road, Street, MD. 21154 Jerome A. Dashner (Husband) 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Bel Air Memorial Gardens, 17/29/99

Memorial Gardens, 17/29/99

About Air Memorial Gardens, 17/29/99

About Air Memorial Gardens, 17/29/99

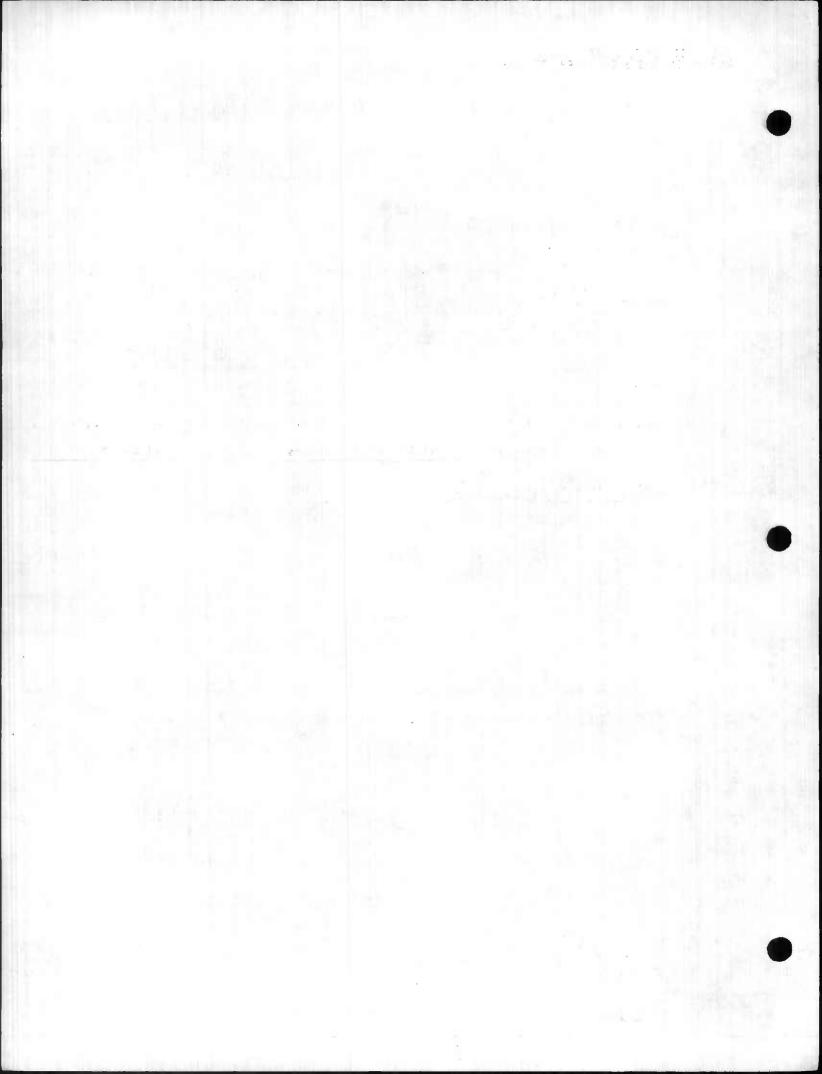
About Air Memorial Gardens, 17/29/99 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licenses 0 610 W. MacPhail Road, Bel Air, MD. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting In death) /Medical SEPSIS 10 bAYS Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 980 Part II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown RENAL à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 1 WNaturat 5 Panding 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🗗 Certifying Physician: To tha best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P12126 JULY 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WALIS AROUGHOUGE 6920 DONACHIE RS #705, BALTIMORE, MS 21239

tut.

State 31. Date filed (Month, Day, Year)
Registrar JUL 2 7 1999

General Signature Sporks

DHMH 16 Ray 6/95



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D 5 5 0 0	17. Father's Neme	17. Father's Neme (First, Middle, Last) Leonard E. Davis Sr.									(First, Middle, Maiden Surneme) Lee Herrin					
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gea 1 a gea 1 a li filem or othe	20a. Method of Dis	sposition	Removal from S	Dana.	Place of Disp cemetery, cre	matory or o	ther pla			Date		on - City or T	own, Stete			

Physician /Medical Examiner

Physician/Medical Examiner Be Completed by Medical Certification: To

To the Hospital or Attanding Physician: The law requires that the death certificate be assouted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detected for use as the burishirasit been signed by the attending physician and ahould be detached for use as the bunal-transit

Division of Vital Records, P.O. Box 68760,

Garrison Forrest VA.7-27-99 Owings Mills, MD. 4 Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22, Neme and Address of Fecility Tri-State Funeral Services 108 W. North Ave. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Intervel Between Onset and Death Immediete Ceuse (Final diseasa or condition resulting in deeth) Narcotic Intoxication Due to (or as a consequence of): Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of with? 4 / Unknown 1 ☐ Yes 2 ☐ No 3 Probably

2 No 1 PYes 2□ No 25. Wss case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1⊠ Yes 2□ No 1 Inpatient 2CER/Outpatient 3□ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 5 Pending Investigation 1 Netural 1 Yes ound:7/17/99Found 5:50PM 2 Accident Unknown 6 Could not be 3 Sulcide 28e. Ptace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homlcide Found 4201 Clare Way Balto City,

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29a	Certifier	1 Certifying Physicia	nn: To the best of my knowledge, death	occurred at the time, date and place, and due to th	e cause(s) and manner as stated.

O.C.M.E.

d cause of deet (Item 23a) (Type, Print)

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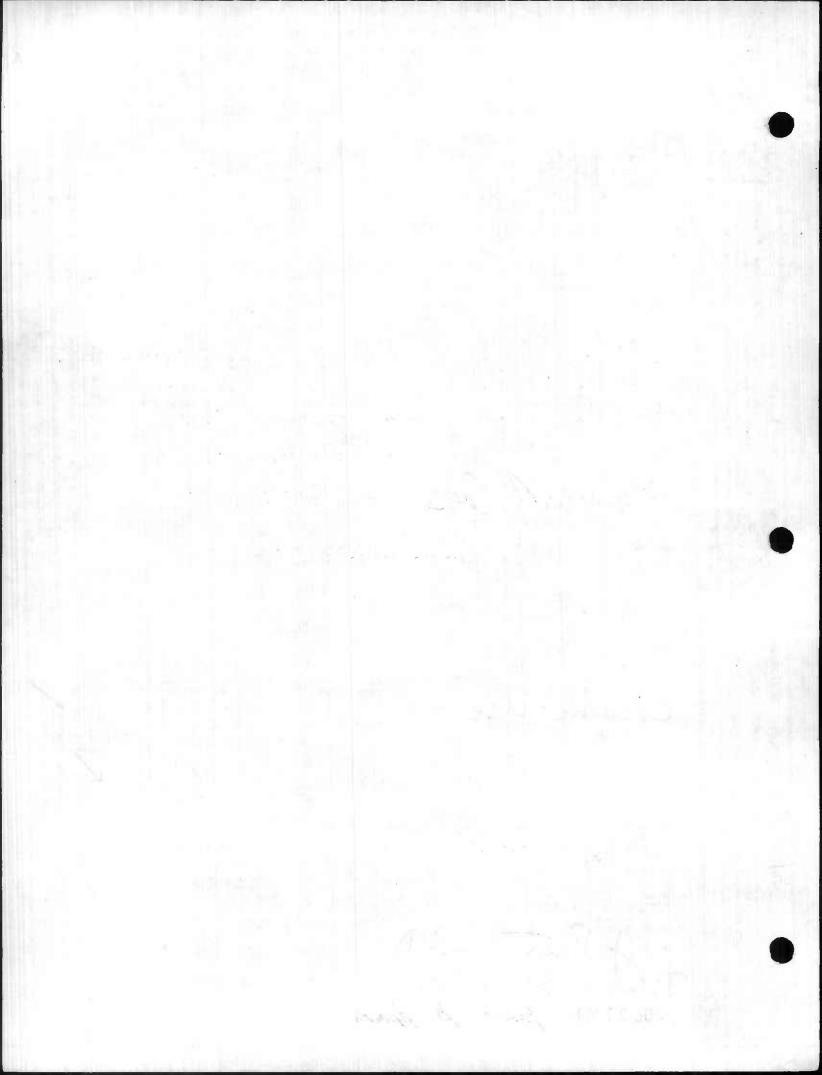
24a. Wes an autopsy performed?.

JULY 18,1999

24b. Were autopsy findings evailable prior to completion of cause of death

31. Date filed (Month Dey, Year) State Registrar

JUL 2 7 1999 32. Registrar's Signature oocks



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State of Maryland / Department of Health and Mental	Hygiene Q Q	2	3 1	Ω	6
Certificate of Death	Pen No	6	UU	0	U

Physici /Medi

Mauro B. Depinto

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Funeral Director

permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Emerical must be notified at

Baitimore, Maryland 21215-0020

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

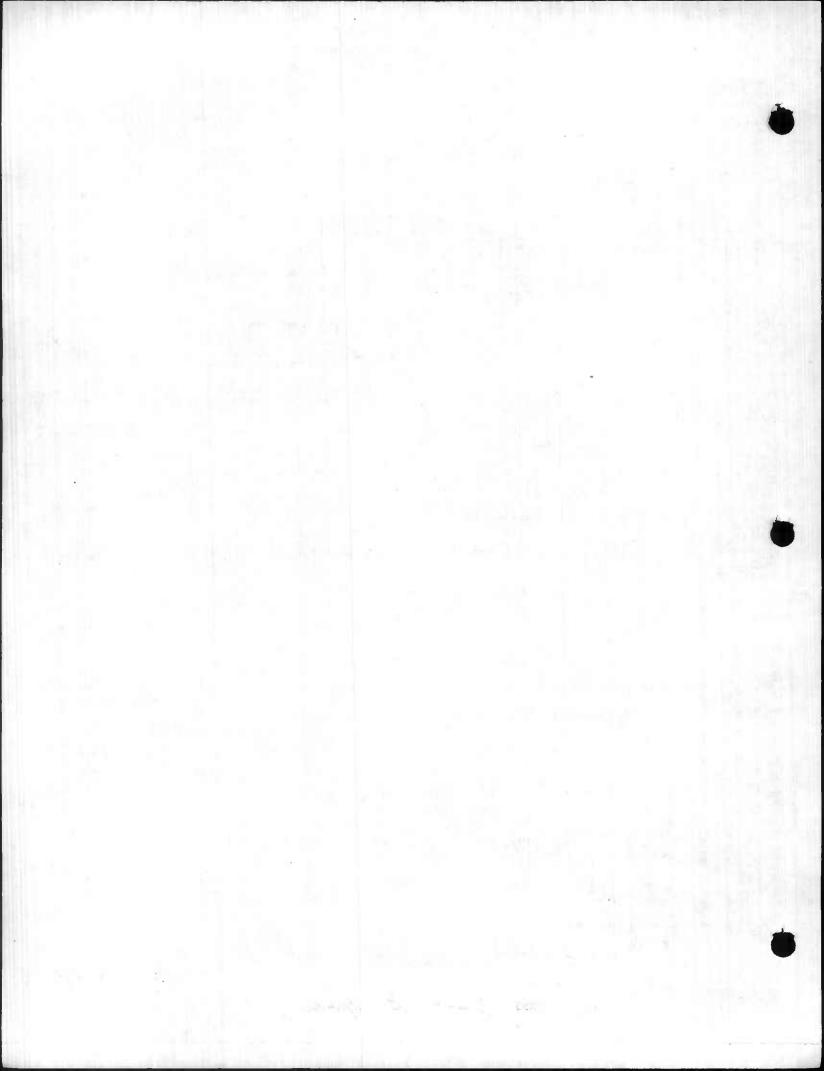
To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Dawn F. McDoi	nald	10000	299	Fred	ericl	Rd	. Balt	imore	, MD	21228
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Was Decodenter Ever in U.S. 14. Was Decodenter Ever in U.S. 15. Decodenta Education (Specity only highest grade completed) 16a. Decodenta 17. Fathar'a Nama (First, Middle, Last) Bernard Benjamin DePinto 19a. Informant's Name/Relationship (Type, Print) Wendy Marie DePinto/daucht 12 Burla 2 Goremation 3 Removal from State 4 Donation 5 Other (Specity) Alpha 12 20 Washington Blvd. 17. Fathar's Name (First, Middle, Last) Bernard Benjamin DePinto 19a. Informant's Name/Relationship (Type, Print) Wendy Marie DePinto/daucht 12 Signature of Poperal Service Ucenses 12 Signature of Poperal Service Ucenses 13 Signature of Poperal Service Ucenses 24 Donation 5 Other (Specity) Dua to (or as a consequence acuse. Enter Underlying Cause (Disease or Injury Cause (Diseases) 25 Was case referred to medical examiner? 26 Page (Disease or Injury Cause) 27 Memorit (Day Year) 28 Page (Dispury Cause) 28 Piace of Injury Cause (Dispury Cause) 29 Piace of Injury Cause (Dispury Cause) 21 Morit (Day Year) 22 Piace of Injury Cause (Dispury Cause) 23 Piace of Injury Cause (Dispury Cause) 24 Morit	Mauro Bernard DePinto 4a Facility Nama (If not institution, give street and number) 6636 Washington Blvd. Lot #112 5. Social Security Number 215-46-5506 5. 8x 7. 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City, Town or Location Filter 10c. State 10c. Street and Number 10c. 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Facility Name (if nor institution, plus street and number) 5a. Sax 7. Aga (in yrs. last birthday) 4b. City, Town, or Location of Death 215-46-5506 3c. Sax 7. Aga (in yrs. last birthday) 8 Under 1 Year 18 Under 24 Hr. 5. Data of Birth 215 50 Vrs. Mornins Days Hours Min. JAN 11, 11, 11, 11, 11, 11, 12, 12, 12, 13, 14, 14, 14, 14, 14, 14, 14, 14, 14, 14	Mauro Bernard DePinto Month Day 21, 1	Mauro Bernard DePinto Merch Day Year As Facility Name (if not institution, pive street and number) 6636 Washington Blvd. Lot #1.12 Social Security Number 215 - 46 - 5506 Re

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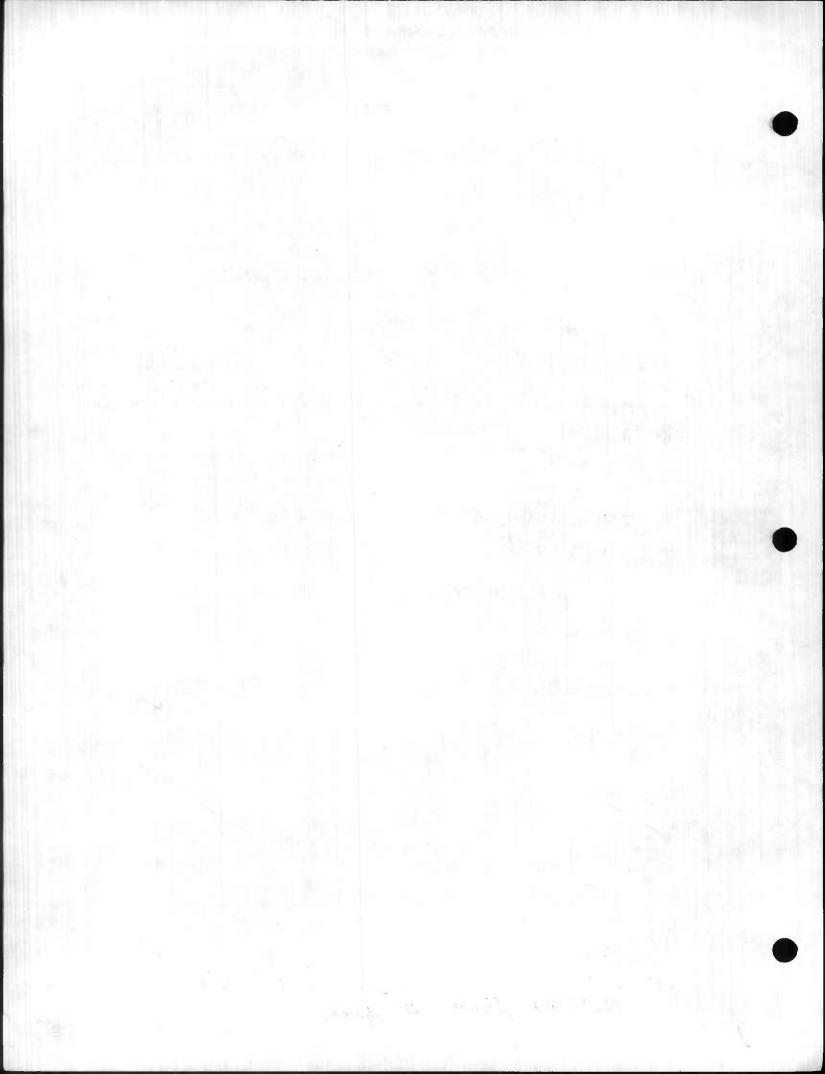


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 8:00 AM **JESSIE** GRUWELL DAYTON JULY 22, 1999 /Medical 4e Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 210 WEST MAPLE ROAD LINTHICUM ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Months Hours 76 Director 222-14-4083 APRIL 22, 1923 DELAWARE Usual Residence of Decedent with the Maryland 10a, Slete 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show must be notified at 1 Yas 2 No Director MARYLAND ANNE ARUNDEL LINTHICUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 234 210 WEST MAPLE ROAD 21090 U.S.A. Funeral death Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U,S. 11. Meritel Stetus Bleck, White, atc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 21215-0020 6 1 Yes 2 No Specify: Specify: WHITE ð 3 ☑ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) TEACHER EDUCATION 12 other Maryland 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Neme (First, Middle, Last) h and Mental It Pages 1 and 2 should be nent of Health and Mental GRUWELL **JEFFERSON** BRACKIN CARRIE **EVELYN** BAYARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Nem 27 l 836 OAKDALE CIRCLE, MILLERSVILLE, MD. 21108 (SON) other STEPHEN DAYTON Baitimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 Cremetion 3 Removal from State permit. Page Department of Important: If any Injury or page. Injury or MEADOWRIDGE MEMORIAL PARK 7/26/99 ELKRIDGE, MD. 4 Dogation 5 Other (Specify) 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 21. Signat re o F Service License 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 see, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician andervaserlan Disease Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed **burial-tran** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. physician Physician/Medical the Due to (or as a consequence of): 8 US6 23b. Did tobacco usa contributa to the cause of death? P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 10 3 Probably 4 Unknown à Division of Vitai Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificata has 1 Yes 21 No 1 Yes or Attanding Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Desidence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Divetural 5 Pending 1 TYes 2 No To the Hospital or Attendition 24 hours after death.

To the Funeral Director: A death. 2 Accident the 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 1 Comfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 rorba 32. Rec State

State
Registrar



State of Maryland / Department of Health and Mental Hygiene Q 23588 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CATHERINE DEARING 23, 1999 JULY 1:10 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ANNAPOLIS ANNE ARUNDEL 2813 BRAODVIEW TERRACE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□M 25 F 217-16-5751 Director 80 OCT. 5. 1918 MARYLAND Usuel Residence of Decedent Manyland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 Yes YNO Director ANNE ARUNDEL ANNAPOLIS MARYLAND the 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 2813 Broadview Terrace 21401 U.S.A. 23a Funeral Nome 2 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Meritel Stetus "natural", or herr Bleck, Whita, etc. should be filed within 72 hours after on Mental Hygiene.

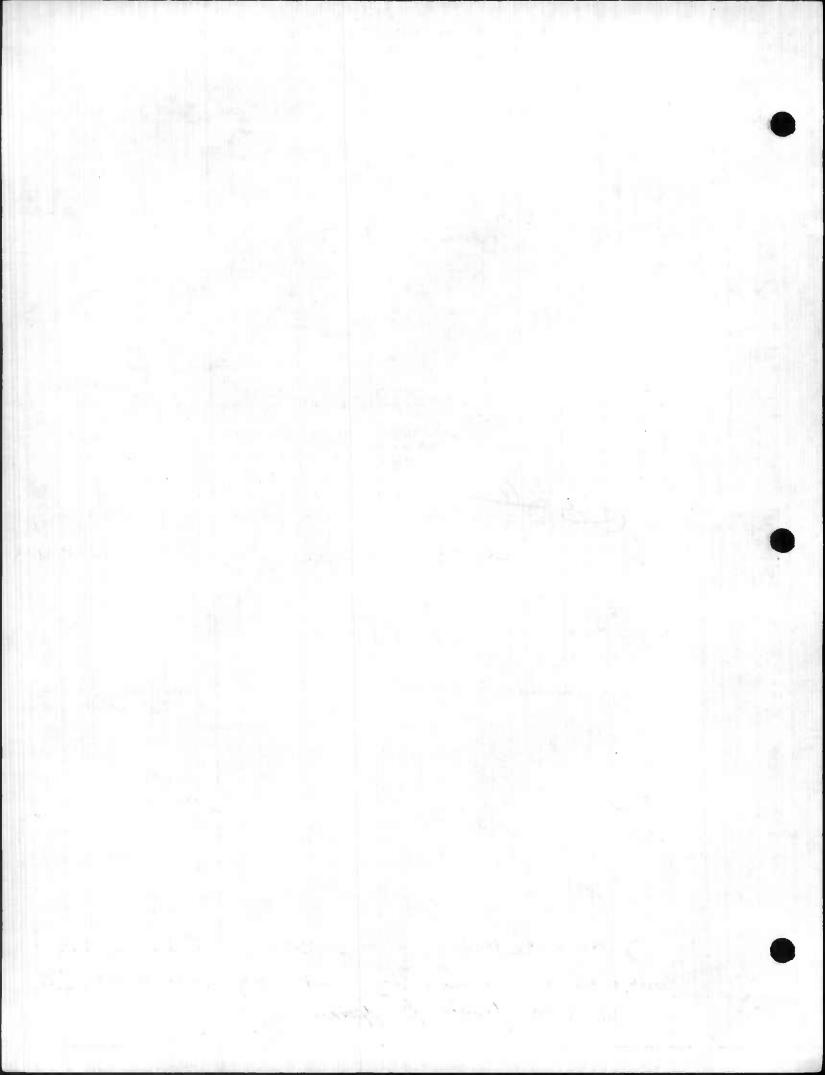
marked other than "natural", or her 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 permit. Pages 1 and 2 should be file.
Department of Heelth and Mental Hygi important: if Nem 27 is marked other:
any Injury or other traument. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be KINKER CAROLINE CHARLES ATKINSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 2813 BROADVIEW TERRACE, ANNAPOLIS, MD. 21401 BETTY LOU DAVIS (DAUGHTER) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, Steta 1 ☐ Burlat 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 7/26/99 GLEN BURNIE, MD. 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 21. Signature of Funeral S 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 or complication that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, thronly one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Just (Finel disease or tion resulting in death) 18 Month Examine Physician/Medical Examiner physician and the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or es a consequence of): USB P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the s should be detached 3 Probably 4 Unknown 1 Yas 2 No Records. à 24b. Wera autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 Yas 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only gne) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Maturel 5 Pending 1 Yes 2 No death. investigation 2 Accident after death 3 Suicide 6 Could not be 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifler edical completely (Check only one) within 2 å 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 0 arkay M.D D39505 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Crain twy, Glen Burnie, 2106, udhishtra Markan 1600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 16 Ray 6/95

JUL 27



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** Ida Elizabeth Duff JULY 1999 23 12:04 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Ct. 16, 1912 Wash. D.C. 7. Aga (In yrs. last birthday) **Funeral** Months Days 1 M 25 F 578-01-8068 86 Yrs. **Director** Usuel Residence of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at page. 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Baltimore Catonsville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1225 Black Friars Road U.S.A. 21228 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-It Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bleck, White, etc. 11 Marital Status 1 Yas 2 No If Yes, Giva Yeer or Detes: 1 Navar Married 2 Married 1 ☐ Yes 2 KNo Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) Prince George Elementery/Secondery (0-12) Coilege (1-4or 5+) Board of Education 12 School Secretary 18. Mother's Neme (First, Middle, Meiden Sumama) 17. Fethar's Name (First, Middle, Last) Otto Keeler Nora Rollins 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) 1225 Black Friars Road, Catonsville, MD 21228 Leo P. Duff (Husband) 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stete Cedar Hill Cemetery 7/27/99 Suitland, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Facility itzke Funeral Homes, Inc. 21. Signature of Funaral Sarvice Licensae 1630 Edmondson Avenue, Catonsville, MD 21228 Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) 3 month Cerebrovasculor Accident Examiner Examiner iper tensit Due to (or ss s consequence of) Sequentielly list conditions, if any, laeding to Immadiate cause. Enter Underlying Causa (Disease or Injury Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I 1 ☐ Yee 2 XNo 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28a. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physicisn: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es ststed.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner stated. 29a. Certifier edical (Check only one) 29b. Signatura and titla of cegli 1227315 29d. Data signed (Month, Day, Year) 30. Name and address of person why completed cause of deeth (tem 23e) (Type, Print) St Agres Hospital 31. Dete tiled (Month, Dey, Year) 32 Registrer's Signature State

Registrar

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After this certificate has funaral director, page 2:

Hospital or Attanding Physician: The lew requires that the deeth certificate be executed

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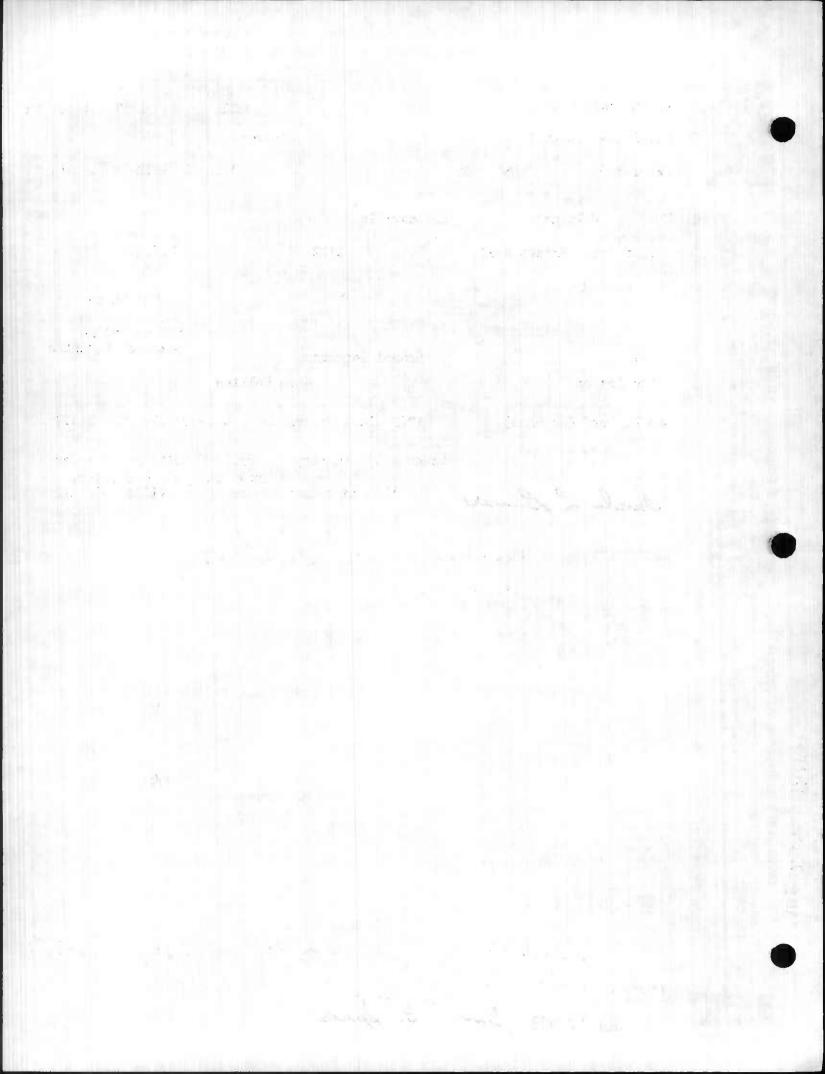
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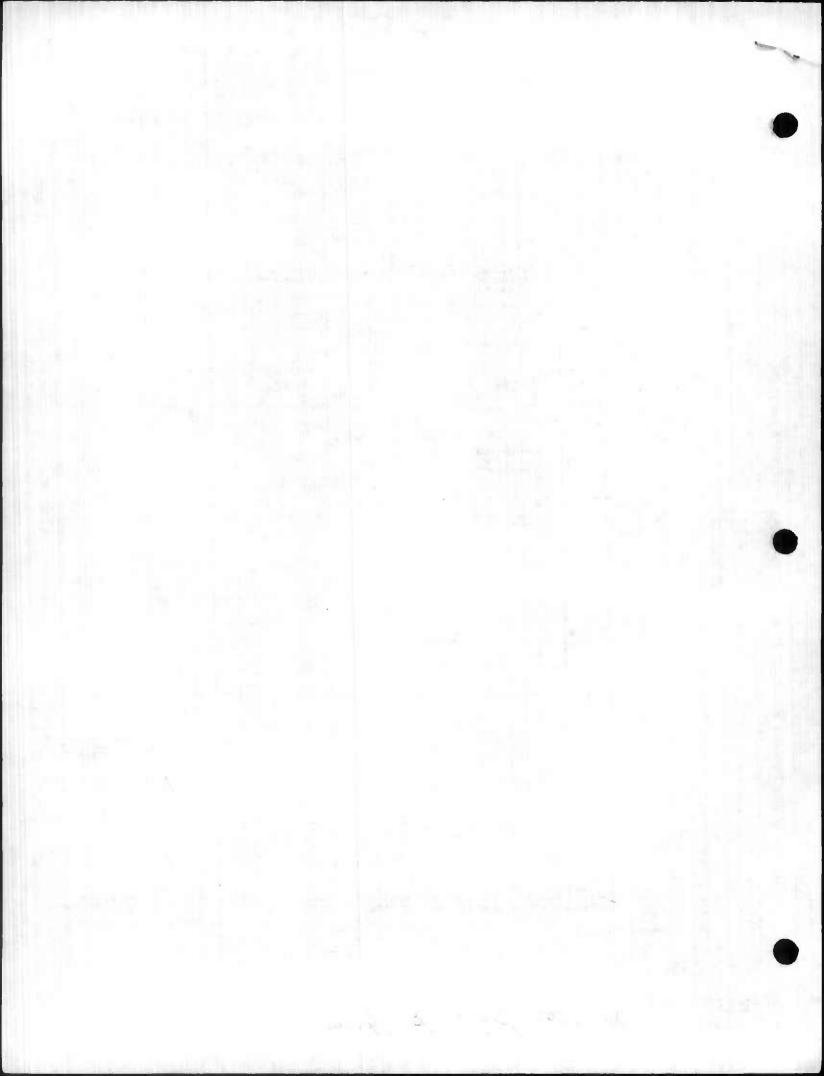
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altimore, Maryland 21215-0020



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Hospi 24 hou Funer taly fil		29e. Certifier Check only one) Medical Exer	ysician: To the bes niner: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the ti n, in <i>m</i> y o	me, date and opinion, deeth	place, and occurred a	due to the o	cause(s) and n date and place	nanner as st , and due to	ated. the cause(s)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** Month 2:35AM Estella Virginia Dorsey /Medical 4a. Facility Nama (If not institution, giva street and number), 4b. City, Town, or Location of Death NURSIN **Examiner** ANDIOWN-WINCHESTER If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yaar) 11 19 1955 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Days 1□M 210 F 43 Director Maryland 219-60-5319 Usual Rasidanca of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ¹X Yas 2 □ No Director 28a-f Md. N/A Baltimore City 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? ថ items 23a 741 N. Fulton Avenue Apt 1 21217 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than "natural", or itel any injury or other traumatic event, the May call Examination. 1 Navar Married 2 Marriad 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) Elementery/Secondary (0-12) Collage (1-4or 5+) Nursing Aide Nursing Home 12th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Robert L. Dorsey, Sr. Ceneiveive Lee 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Geneiveive Johnson/Mother 741 N. Fulton Avenue, Baltimore, Md. 21217 20b. Placa of Disposition (Nema of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 7/26/99 Landsdowne, Maryland Mt. Zion Cemetery 22 Name and Address of Facility William C. Brown Community FUneral Home 21. Signature of Funaral Sarvice Licanse 1206 W. North Avenue, Baltimore, Maryland 21217 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final -MMUNE DETICIELLY disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner Sequantially list conditions, if any, laading to Immadiata causa. Enter Undarlying Cause (Diseesa or Injury that initiated avants resulting in death) Lea Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Be Completed by 24b. Were autopsy findings available prior to 24a. Was an eutopsy complation of causa of death? 25. Was casa referred to medical axaminar? 26. Placa of Death (Check only ona) Othar: Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) Medical Certification: To 1 🗌 Yas 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral Manner of Deat 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Panding within 24 hours after death.

To the Funeral Director: A completely filled in by the fu invastigation 1 Yas 2 🗆 No 2 Accidant 3 Suicida 6 Could not be determined Plece of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stete) 4 Homicida Certifying Physician: To tha best of my knowledge, daeth occurred at the time, dete end plece, end dua to tha cause(s) and manner as stated.

2 Madical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete and place, and dua to the cause(s) and manner stated. 29a, Cartifian 29b. Signatora and titia of cartifiar 29d. Date signed (Month, Day, Year) 29c. Licansa number

State Registrar

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Baltimore, Maryland 21215-0020

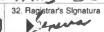
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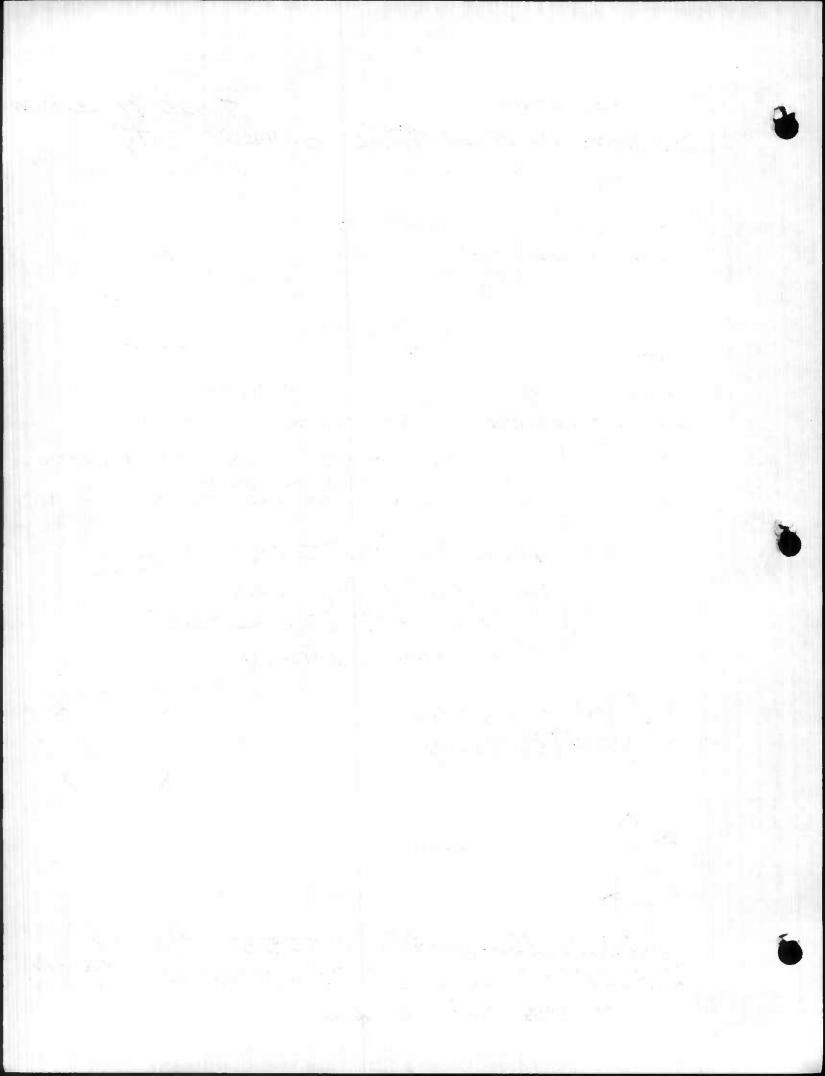
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (Certificate of Death 1 Decedent's Name (First Middle Lest) 2. Data of Death 3. Time of Death Month July 24, Earl Henry Durbin 1999 2:03 P.m. 4a. Facility Neme (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Manor Care-Rossville Baltimore Baltimore 5. Sociei Sacurity Number If Under 1 Yaar | If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Days Hours 1⊠M 2□ F Yrs 214-26-5643 82 Nov. 6, 1916 Maryland Usuel Rasidance of Dacedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes PNo Maryland Baltimore Middle River 10e. Streef end Number 10f. Zlp Coda 10g. Citizen of What Country? 109 Conestoga Road 21220 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? ► Yas 2 □ No If Yas, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Rece - American Indian, Black, Whita, atc. 11. Meritel Status 1 □ Navar Married 2 □ Married 1 ☐ Yas 2 XNo Specify: ₩idowad 4 Divorced White 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Highway Department 6 17. Fether's Neme (First, Middla, Last) 18. Mothar's Name (First, Middle, Meidan Sumama) Joseph E. Durbin Bertha I. Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, State, Zip Coda) Carol J. Botteon (daughter) 109 Conestoga Road , Baltimore, Maryland 21220 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XXX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Green Mount Crematory 21. Signature o Funarai Service Licensaa 22. Nama and Addrass of Facility Bruzdzinski Funeral Home, P.A. 23a. Pert1. Entar tha disease, or complications that ceused tha death. Do not aniar tha mode of dying, such as cardiac or respiratory errest,

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Physician /Medical **Examiner**

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7 is marked other than "natural", or iten traumatic event, the Medical Expresser

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and Mental Hygiene.

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Baltimore, Maryland

page 2 should

The law requires that the death certificate be executed

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Physician/Medical by Completed Be 2 in by

To the within 2 State Registrar

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29a, Cartifiar

(Check only one)

Medical

Invastigation 6 ☐ Could not be datarminad 4 I Homloida

> XXX Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as steted. 2 Medical Examiner: On the bests of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

28a. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Tima of

28a. Data of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

28f. Location (Straet end Number or Rural Routa Number, City or Town, Stata)

1 ☐ Yes 2 ☐ No

1 Yas 2 NHo

28d. Dascribe how injury occurred

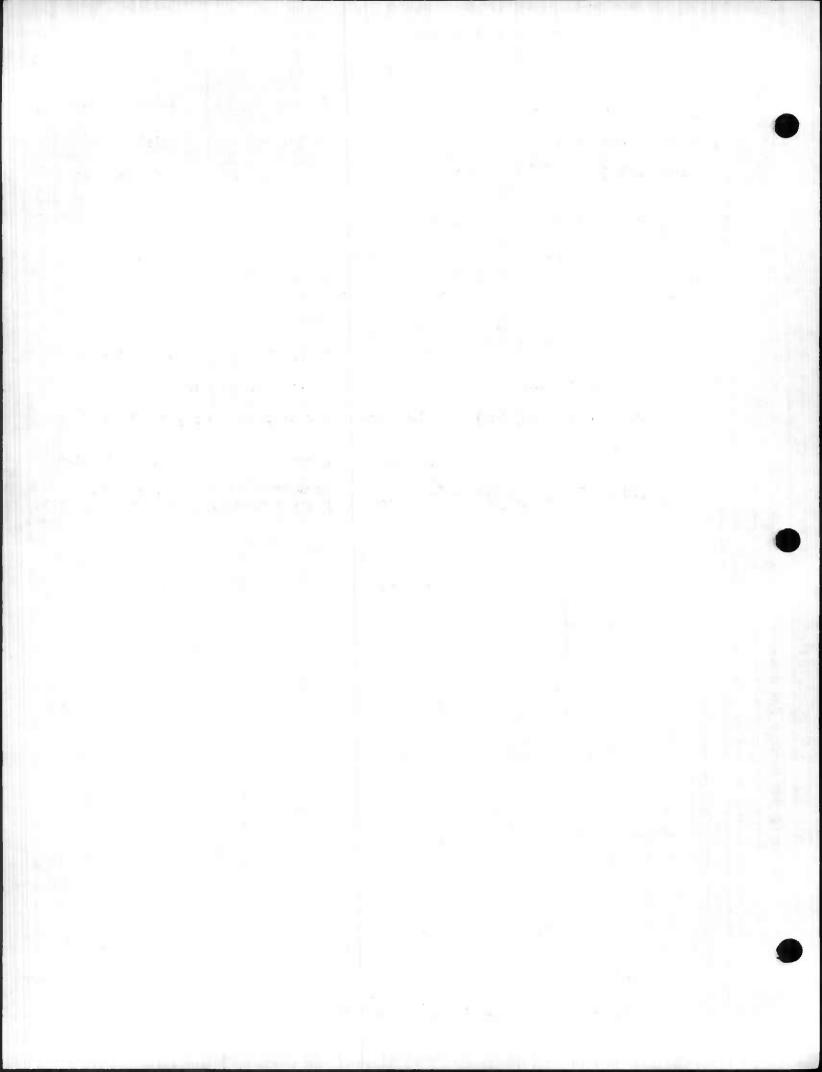
26. Place of Death (Check only one)

Othar: 45 Nursing Homa 5 Rasidance 8 Othar (Specify)

30. Nama end address of person who complated causa of death (Itam 23a) (Type, Print)

KOUIIMO 7600 OSCER Drive suite 203 Towson, MD 21204

31. Date filad (Month, Day, Yeer) JUL 27 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 12:15 PM 1999 Edward A. Ellison, Jr. JULY 23 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore St. Agnes Hospital If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) M 20 F Months Deys Hours 033-20-5843 70 Massachusetts Usual Residence of Decedent 10b County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 640 Aldershot Road 21229 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Amped Forcea? 1 △ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried WWIT 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5 + Elementery/Secondery (0-12) Insurance Broker Insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Edward A. Ellison, Sr. Florence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 640 Aldershot Rd. Baltimore, MD 2122
Date | 20c. Location - City or Town, State Alice Anderson Ellison/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 N Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 7/24/99 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility and. To Small Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Road

23a. Pert. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respire shock, or heef tellure. List only one cause on each line. Baltimore, MD 21228 Interval Between Onset and Death Immediate Cause (Finel diseesa or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Melli Due to (or es a consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 27 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 27. Menner of Dath 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

and the P.O. Box KDMARD this After

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

72 hours after

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permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygiene Important: if frem 27 is marked other tha any injury or other treumatic event, that page.

Physician /Medical

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edicai Certification: To

2 Accident

4 Homicide

29b. Signeture end title of certifier

3 ☐ Suicide

29e. Certifier

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

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after death. To the Hospital
within 24 hours a
To the Funeral C
completely filled

> State Registrar

Thom form, Min

28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify)

29c. License number D 51088

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2/ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

> 29d. Date signed (Month, Day, Year) JULY 1999

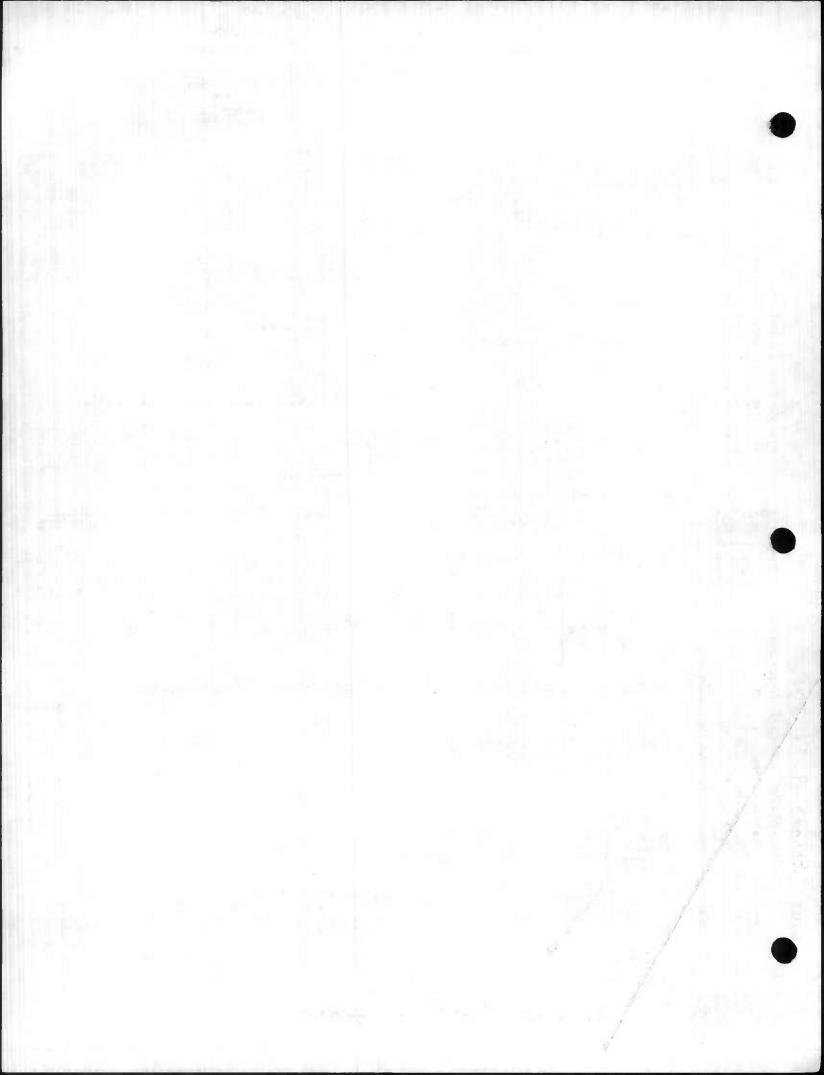
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THAW ROON, St. Asens Hespital, 900

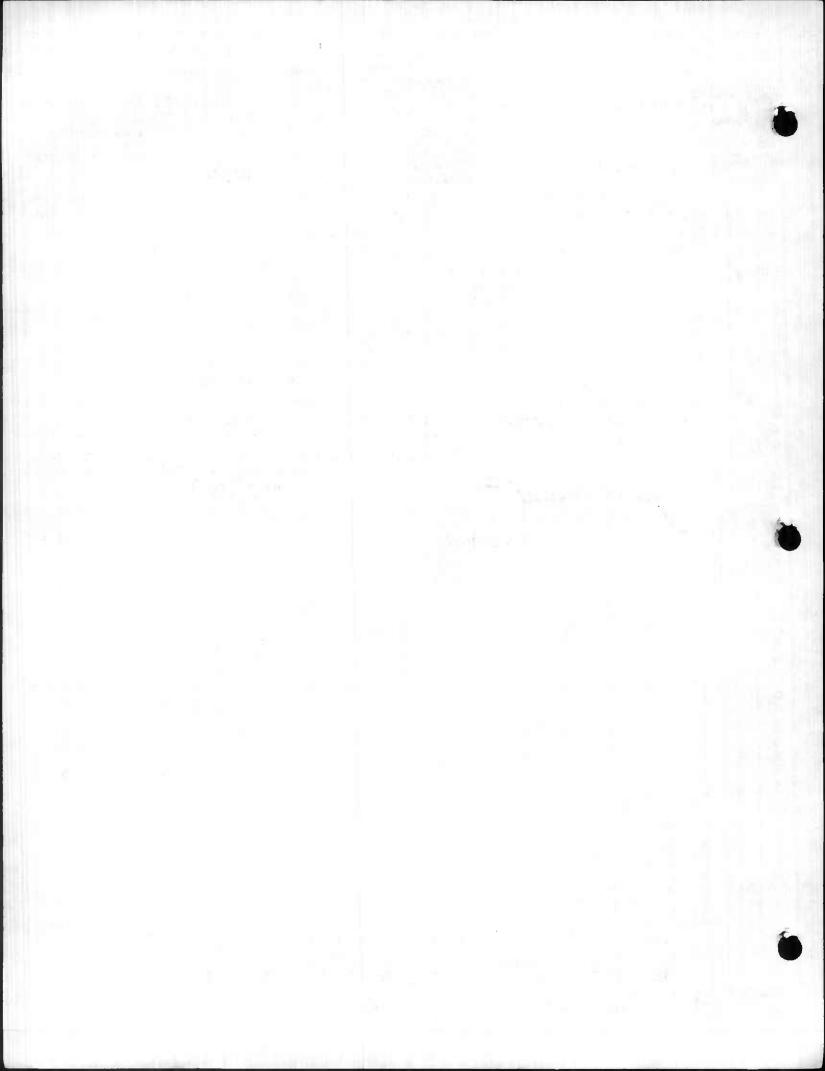
Investigation 6 Could not be determined

Caton Are , Baltimory, MD 21229

31. Date filed (Month, Dey, Year) 32. Registrar's Signature JUL 27 1999



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	Dhualai	lan.	1. Decedant's Nama (First, Middla, La	•					2. Data of D	eeth	Voor	3. Time of Deeth		
3	Physici /Medi		Katherine Ridgely						Mogiful	_Y 25,	1999	12:30 P		
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	ath with	Funeral Director	509 E. Joppa Rd.				21286			Unite	d Stat	es		
21215-0020	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heeith and Mental Hygiana. If item 27 is marked other than "natural", or itema 23a or 28a-f ahow or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Stetus 1 □ Navar Married 2 □ Married 3 ሺ Widowed 4 □ Divorced	12. Wes Dacedant Armed Forcas? 1 ☐ Yes 2 X I If Yas, Giva Year or Datas:	Evar in U,S No		as Decedant of ∕as, specify Cu ☐ Yas 2 <mark>X</mark> No	Hispanic Origin? (ban, Mexican, Pue	Specify Yas or N rto Rican, atc.)		ce - American ick, White, etc fy: Whit	c.		
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d 2	Hygia ther	ပိ	17. Father's Name (First, Middle, Last)			LE	eacher	18 Mother's No	ama (First Middl	a, Maiden Sumai				
an	d be sental	To Be	Joshua Ridgely						Reese Me		110)			
Maryland	shoul nd Me mark mark	ř	19a. Informant's Name/Relationship (vpe, Print)		19b. Mailing	Addrass (Stree	et and Number or F			Stete. Zip C	oda)		
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of V	5 00 0	2	1 Yas 25 No	Hospital: 1 Inpatia	nt 2 E	R/Outpatient	3□ DOA O	thar: 4 Nursing	Homa 5□Ras	sidence 8 🗆 Ott	ner (Specify)			
	and the	0.0	27. Manner of Death 1 DNatural 5 ☐ Panding 2 ☐ Accidant invastigation	28a. Data of Inju (Month, Da)	y Year)	28b. Tima of Injury	28c. Inj W M 1[uryat ork? ⊒Yas 2 ⊒ No	28d. Dascribe	how injury occur	rred			
Division	tel or Attendi rs after deeth. al Director: A led in by the fi	Certification	3 Suicide 6 Could not be datermined	Э	28f. Location (Street and Number or Rural Route Number, City or Town, Stata)									
	To the Hospital or / within 24 hours after To the Funeral Direction Completely filled in the Funeral Direction of the Fun	edical	29e. Cartifiar (Check only one) Certifying Physician: To tha best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) end manner as steted. Medical Examinar: On tha basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s and manner stated).											
	withir To the	Me	E 29b. Signatura and titla of certifia: 29c. License number 29d. Data signed (Month, Day, Y											
j			Janding 1,	mulli,	m-	D	D 4	1410	Ju	ly 25/1	,19	99.		
			30. Nama and eddless of person who of JOGINDER P. ME	omplated causa of d				DR., TO	WSON, N	1ARYLAN	D 21	204		
	Sta		31. Data filed (Month, Day, Year)	32 Registra	ar's Signati	Lire Li	1-1							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 730 Ellerbe Year James AM 07-99 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death BALTIMORE HINNEY AVENUE 5. Social Sacurity Number If Undar 1 Yaar If Under 24 Hrs. Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 244-18-1485 10 M 20 F Months Days Hours 89 Yrs. NC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No NIA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4428 USA 21215 TVENUE 12. Was Dacedant Evar in U,S.
Armed Forces?
1 2 Yas 2 1 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marltai Status 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15 Decedant's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elemantary/Secondary (0-12) Collaga (1-4or 5+) ASSISTANT NURSES HOSPITAL UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) JAMES ELLERBE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE KOBERTA ELLERBE HINNEY BALTO MD. 21215 20b. Place of Disposition (Name of cemetary, crematory or other place)

CARRISON FOREST 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Removal from State JARRISON. 7.30.99 OWINGS MILLS, MO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATE PIKE, BALTO. au 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrast, shock, or heart-failura. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final cerebrovascular disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Undarlying Cause (Disease or injury that initiated avants resulting in death) Last Dua to (or as a consequenca ot): Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1X Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examinar? 26. Piace of Death (Check only one) Othar: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Deatl 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? 1 Naturai 2 Accident 5 Pending investigation 1 ☐ Yas 2 ☐ No

Examiner Box 68760. P.0. Records, Division of Vital

certificate be executed physician Physician/Medical the detached signed by the p 9 **Be Completed** peed certificate has lector, page 2 s certificate Physician: 2 this Certification: After or Attending death. To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f Medicai

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Herns 23a

ö

"natural",

traumatic event, the Medical

marked other than

permit. Pages 1 and 2 should be file.
Department of Health and Mentai My Important: If Item 27 is marked other any injury or other treumatic avera-

Physician /Medical

Examiner must be notified at

Director

Funeral

p

Completed

Be

the Maryland

death

72 hours after

Baltimore, Maryland 21215-0020

State Registrar

31. Date file Registrar's Signature

6 Could not be determined

3 Sulcide

29a. Certifier (Check only

4 Homicida

29b. Signatura and title of certifier

mpleted causa of daath (Item 23a) (Type, Print) MD

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

29c. Licansa number

Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as ataled.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29d. Date signad (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N. GreeneSt Baltimore MD

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time the **Physician** Year FOWLER JULY 22, 1999 2:45 AM /Medical 4a. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Saint Joseph Medical Center Towson Baltimore 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 128-09-7184 Deys 1)⊠M 2□ F Yrs. Director 0 109 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1⊈Yes 2□No Director Altimore 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? ŏ 21218 3904 5. items 23a Alemeda 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bieck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or item eny injury or other traumetic event, tra Mexical Exercises. 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: BIACK þ Specify. 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade comp 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NQT use retired) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) WORKER 17. Fether's Neme (First, Middle, Last) Be lowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillie BAlto. Alemeda MD 21218 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State BAltimore MEMORIA 7/28/99 5 ☐ Other (Specify) PACK 21. Signeture of Funerel Servica Licansee 22. Neme end Address of Fecility Funeral 1/29 5%. , MP. Q1213 23a. Pert1. Effer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or hear failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final RESPIRATORY FAILURE diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner PNEUMONIA The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immadiate causa. Enter Undarlying Cause (Diseese or Injury that initiated events resulting in death) Last and Due to (or es e consequence of): ettending physician a for use as the burial-P.O. Box 68760, Physician/Medical the Due to (or as a consequence of). 88 Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by the No CHRONIC OBSTRUCTIVE PULMONARY DISEASE 3 Probably 4 Unknown Records, Be Completed by cate has been sig 24b. Were eutopsy findings evailable prior to completion of cause of daeth? 24a. Wes en eutopsy performed? CORONARY ARTERY DISEASE 1 ☐ Yes 2 No 1 Yes certificate Division of Vital the Hospital or Attending Physician: director, 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2N No edical Certification: To 1) Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27, Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After 5 Panding Investigation 1 Neturel 2 Accident To the Hospium - ... within 24 hours after death.
To the Funeral Director: After a contained filled in by the fur 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be datemined 28e. Piece of injury - At home, ferm, street, factory, office building, atc. (Spacify) 4 Homicida Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and piece, and dua to tha causa(s) and menner as steted.

2 Medical Examiner: On the basis of axamination end/or investigetion, in my opinion, deeth occurred at tha tima, data and piece, and due to the causa(s) end manner stated. 29a. Certifian 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

JUL 27 1999

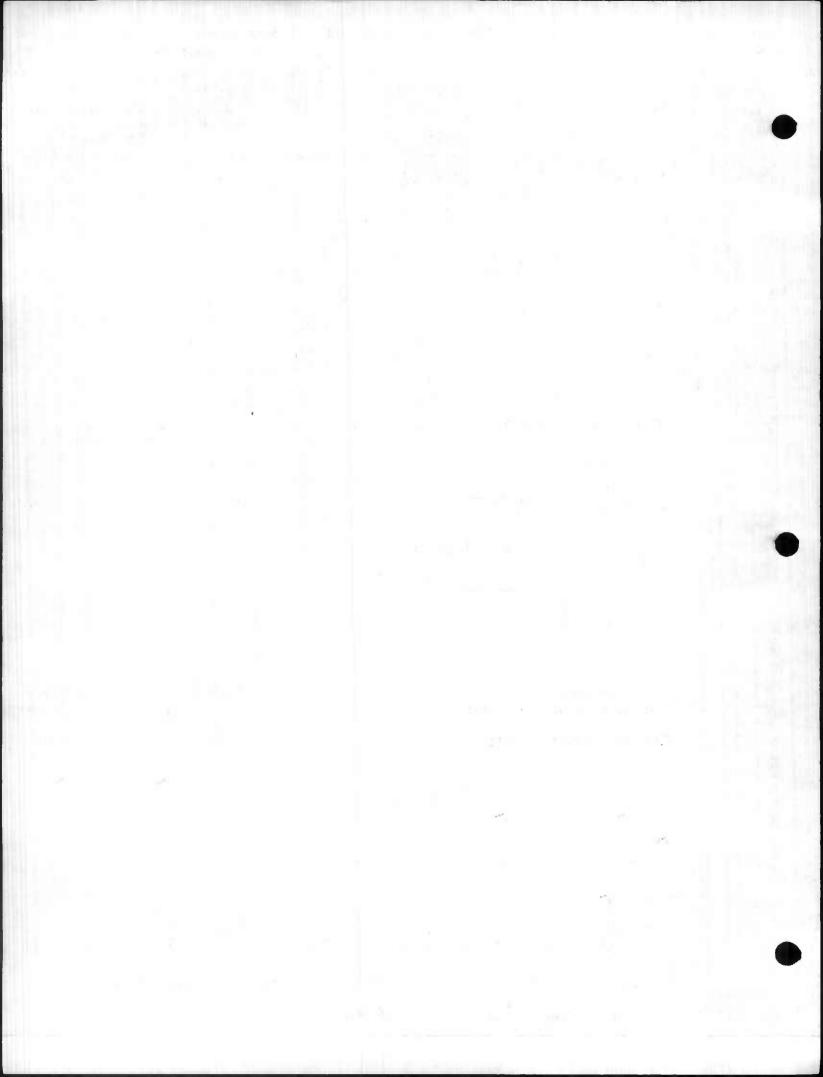
31. Dete filed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



30263

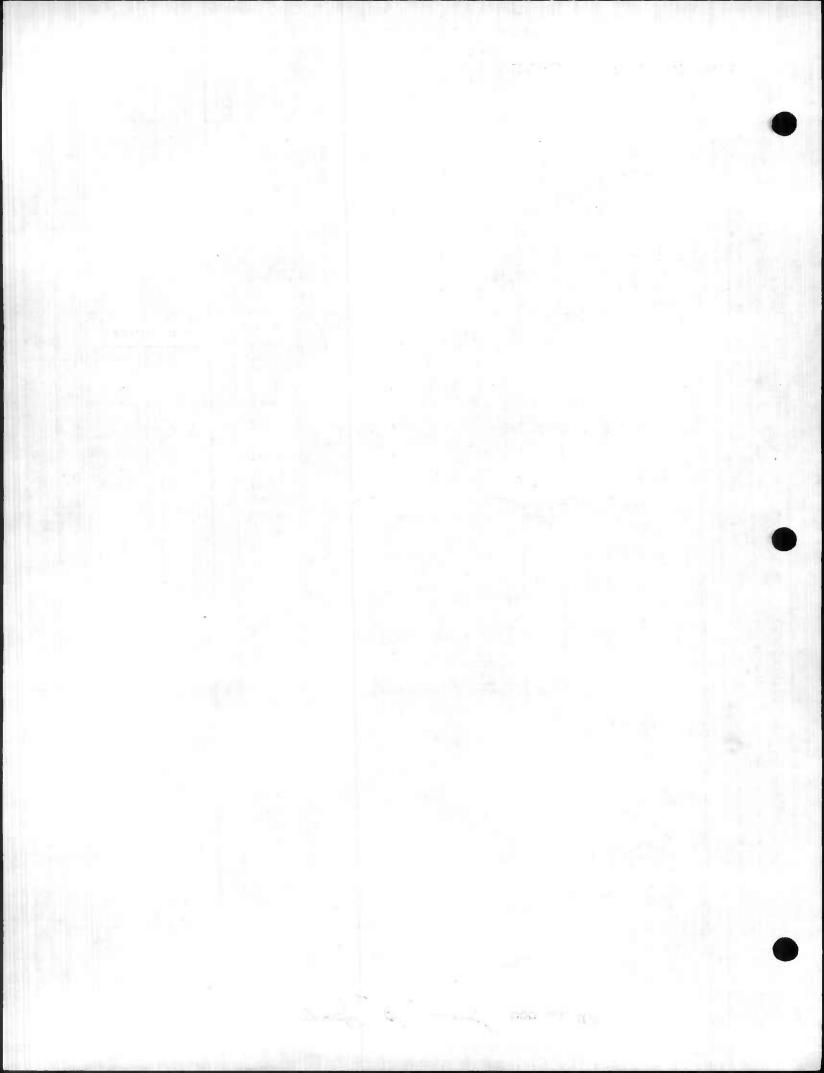
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	State of Maryland / Department of Health and Mental Hygiene 235

	Amend	ed Items#7,16b perFH	G773 7/27/99 EW	1	Certificate of	Death	Re	ig. No.			
	Physiciar	1. Decedent'a Name (First, Mid SAMUEL	die, Last)	FINK	ELSTEIN		2. Dete of Death	h Dey Year	3. Time of Death		
5	/Medica				20022111	4b. City, Town, or I	JULY	1			
	Examine							4c. County of Dee			
-		4 STONEHENGE			thday) If Under 1 Yeer	BALTIMO	RE 8. Date of Birth	BALTIMO			
	Funeral Director	5. Social Security Number 218-12-6471 Uaual Residence of Decedent	6. Sex 7. Ag	e (tn yrs. last bii 96	Yrs. Months Days	Hours Min. APRIL 10, 1903 RUSSIA					
	Para I	10a. Stete 10b. Coun	ly	10c. City, Tow	n or Location				10d. Inside City Limits		
	vith the Marylan to cr 28a-f ahow to notified	MD BALT	TIMORE	BAL	TIMORE				1 □ Yes 2√□ No		
	23a or 2	10e. Street and Number 4 STONEHENGE	E CIRCLE AP	т. 5	10f. Zip Code 21208	3	10	Og. Citizen of What Co	ountry?		
020	be filed within 72 hours after death with the Maryland tel Hygiene. I other than "natural", or hema 23a or 28a-f ahow event, or Medical Emerican must be notified at Parallel Emerican International Physics of the Completed But Emerican Directors.	Widowed 4 □ Divorce	H Vac Giva A		13. Wes Decedent of I tt Yes, specify Cub	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Rece - Ame Bleck, Whit	le, etc.		
20	n 72 ho natur edical	15. Decede	ent's Education est grade completed)	16a.	Decedent's Usuel Occu (Give kind of work done	pation	kina	16b. Kind of Business			
21215-0020	12 should be filed within 72 hours h and Mental Hygiene. Tis marked other than "natural", traumatic event, the Medical Ess	Elementary/Secondary (0-12)		i+)	life. DO NOT use retire PROPRIETOR	nd)		Haberdashery I ABADASHR			
D	He He	17. Father's Neme (First, Middle	o, Last)			18. Mother's Nen	ne (First, Middle, N	faiden Sumeme)	-		
Maryland	Mental H Mental H inked off rtic ever	FISHEL	FT	NKELST	ETN	ANNE		GROSSM	IΔN		
Z	should in Men in Marketic	19a. Informant's Name/Relation			. Mailing Address (Street		rat Route Number.				
Š	2 4 4 5				417 OLD CO						
e,	of Health Hem 27	MARSTON ADLE 20a. Method of Disposition	CR/ NEPHEW	20b. Place 0	Disposition (Name of			. MORE ML 20c. Location - City or			
altimore,	Page H		3 □Removal from State (Specify)		ry, crematory or other pla TFILOH CON	NGREGATI	123/99.	OODLAWN,			
8	Physician /Medical	23a. Parl. Finter the disease, sinck or hear feilure. Li	511		not enter the mode of dyi	STERSTOW ing, such as cardiac	N ROAD or respiretory arre	PIKESVIL	OS. INC. LE MD 2120 Approximate Interval Between Onset and Death		
	Examiner	disease or condition resulting in death)	a	Due to (or as e	Consequence of):	HETRICT	DISO	45/	13813		
			CQ	~(CFS	TTOIS 1	4rse -	FAJEL	URK	DYRS		
,	rdificate be executed ng physician and set the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			consequenca of):						
68760	ysicle burden	Cause (Disease or injury that initiated events resulting in death) Last	С	Due to (or es a	consequence ot):						
	De S		d								
Box	the death code by the attend letached for us										
o	bed hed	Pert II. Other significant condit	tons contributing to death be	ut not resulting i	n the underlying cause gi	ven in Pert I.			a to the cause of death?		
S, P.	es that it igned by be detach		PRIRETALS &	ans _			1 🗆 Ye	98 207No 3□F	robably 4 Unknown		
Record	been s should should						24a. Wes as perform		Were autopsy tindings available prior to completion of cause of death?		
	ysician: The lav sis certificate has director, page 2 fo 8e Como						1 □ Ye	s 250	1 ☐ Yes 2 ☐ No		
Viita	entifica sctor, i		al			26. Place of Dec	oth (Check only on	9)			
>	Physician: this certific and director,	axeminer? 1 ☐ Yes No	Hospital:	nt 2 ER/Ou	utpatient 3 DOA Ot	her: 4 Nursing H	ome Reside	nce 6 Other (Spe	ecity)		
O	2 2 -		28a. Dete of Inju (Month, De	ry 28b.	Time of 28c. tnju	ry at	28d. Describe ho	w Injury occurred			
Ö	ath.	1 Netural 5 Pend 2 Accident inves	tigetion (Month, De	y / 601/		Yes 2 No	1010				
Division	tal or Attending Ph. rs after death. al Director: After thi ed in by the funeral Certification: 7	3 Suicide 6 Could deter	d not be mined 28e. Plece of Inju- building, etc	ury - At home, fe c. (Specify)	erm, street, fectory, office		28f. Location (St. City or Town	reet and Number or R , State)	turat Route Number,		
	Hospital A hours Funeral tely fillex Ilcal C		ing Physician: To the best of	examinetion en	e, deeth occurred et the ti	ime, dete end place opinion, deeth occu	, end dua to tha ca rred at the time, da	use(s) and manner a ate and placa, and du	s stated. e to the cause(s)		
	within 2 To the comple		and manner ste	neu.	29c. Licen	se number	29	9d. Dete aigned (Mon	th. Dev. Year)		
	5.¥58	250. Orginatura and ina or contin			200.	00		7/2	156		
	~/	1400	you		1	7731	/	1/20	177		
	10	30. Nema and address of perso	n who completed cause of d	eath (Item 23a)	(Type, Print) STE 300	BALTE	Molt	mp 21	202		
	State	31. Dete filed (Month, Day, Yea	7) 32. Registr	ar's Signeture	4 1	1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland / Depa	triment of Health and tificate of Death		ene 99	23598
Physi /Med		Decedent's Name (First, Middla, Last) Clement John Fuka		2. Data of Death Month July 2	Day Yea	3. Time of Death 9:10 PM
Exam		4a. Facility Name (If not Institution, give street and number) Gilchrist Nursing Center	4b. City, Town,	or Location of Death	4c. County of De Baltim	eath
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 215-01-2588 1 1 M 2 F 81 Yrs.	If Under 1 Year If Under 24 It Months Days Hours M	tin. (Month, Day,		hirthplace (Stata or Foreign Country) Maryland
ryland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc				10d. Insida City Limits
with the Maryland a or 28a-f show	Director	Maryland N/A Baltimon				1 ¥ Yes 2 □ No
with I		5715 Anthony Avenue	10f. Zip Code	10	g. Citizen of What (Country?
15-0020 72 hours efter death with the Maryland *natural', or items 23s or 28s-f show olded Examiner must be notified at	by Funeral	11. Marital Status 12. Was Decedant Ever in U,S. Armed Forces? 1 □ Never Married 2 ☑ Married 12. Was Decedant Ever in U,S. If	21206 Vas Decadent of Hispanic Origin? Yes, specify Cuban, Mexican, Pt ☐ Yes 2 No Specify:	? (Specify Yes or No- uarto Rican, etc.)	U.S.A. 14. Raca - An Black, Wi	
F . F . C .	Completed	(Specify only highest grade completed) (Give I Elementary/Secondary (0-12) Coilege (1-4or 5+)	ent's Usual Occupation kind of work done during most of OO NOT use retired) Counting Departi	working	6b. Kind of Busines Beth Ste	,
and 21; be filed wit ntel Hygiene of other the	BeC	17. Father's Name (First, Middla, Last)		Name (First, Middle, M		G 1
Maryland d 2 should be file th end Mentel Hy 7 is marked othe traumatic event,	2	Francis Fuka	Anı			etr
Maryla		0 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	g Address (Street and Number of	r Rural Route Number,	City or Town, State	, Zip Code)
Baltimore, IN permit. Pages 1 end Depertment of Health Important: If Itam 27 any injury or other tr		20a. Method of Disposition 1 20b. Place of Disposicametery, crem	me as 10 sition (Name of atory or other placa) od Cemetery		Oc. Location - City of	
Balti permit. Depentra Importa any inju		21. Signature of Funerai Sarvice Licensee Paul L. Hartsock, Jr. 22.			re,Maryla	
m saffs	SI.	Heart L. Hantsoch its Le	onard J. Ruck,	Inc. 5305	Harford	Rd.
Physician /Medica Examine		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	ary fibro uence of): fial pne			Approximate Interval Between Onset and Death
ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einter Underlying		umiti	S	years
OX 68/6U, certificate be executed ading physician and use es the buriel-transit	edical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence of	ence of):			
death cert death cert e attending	Iclar	Part II. Other algnificant conditions contributing to death but not resulting in the un	dashina asuna akun ia Dashi	OOb Distant		1
of the second	by Physician/M	Take Substituting to death but not resulting in the un	Jenying Cause given in Fait I.	1 TY6	te.	te to the cause of death? Probably 4 Unknown
aw requires to been sing 2 should	Completed k			24a. Was ar perform	autopsy ed?	available prior to completion of cause of death?
al K				1 □ Ye	2 No	1 ☐ Yes 2 ☐ No
Phys ral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Other	g Home 5 Rasider 28d. Describe hor	nce 6 Other (Sp	pocity) Hospice
= 505>	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Str. City or Town,		Rural Route Number,
To the Hospital or A within 24 hours efter To the Funeral Direction of the Completely filled in b	edical	29a. Certifier (Check only one) Certifying Phyaician: To the best of my knowledge, death (2 ☐ Medical Examiner: On the basis of examination and/or invitable) and manner stated.	occurred at the time, date and pla estigation, in my opinion, death of	ace, and due to the ca courred at the time, da	use(s) and manner te and place, and de	as stated. ue to the cause(s)
To the Within 2 To the comple	Me.	29b. Signatura and title of cartifier	29c. Licanse number	29	d. Date signad (Moi	nth, Day, Year)
		M Brothny Kiley, mo	025205	J	Jly 26,	1989
		30. Name and address of person who completed cause of death (Item 23a) (Type, F. W. A. R. Ley (GBMC 670) N. C.	charles It	Balto 1	nd zr	205
S Regis	ate trar	31. Date filed (Month, Day, Ydar) 32. Registrar's Signature	backs			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23599 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day 5:30 pm Ernest O. Fair 07 4e Facility Name (If not institution, give street and number) 2. South Greene Streets. City, Town, or Location of Death 4c. County of Death University of manyland MEDICAL SYSTEM Baltimore, MD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 1KM 2□ F 08,16,37 Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Joppa 1 ☐ Yes 2♥ No 10f. Zip Code 10g. Citizen of What Country? 1012 Rosemont Drive 21085 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Owner-operator Music Store 18. Mother's Name (First, Middle, Maiden Sumame) Oliver O. Fair Margaret Bartholow

Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)

5. Social Security Number

215-34-2030

10e. Street and Number

11. Marital Status

10a. State

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f ahow

natural, or

I Hygiene.

permit. Peges 1 and 2 should be fliat Department of Heath and Mentel Hy Important: If Item 27 Is marked oth any Injury or other traumatic event bings.

Physician /Medical

Examiner

physician and the buriel-transit

Box 68760

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Records,

Division of Vitai Attending Physician:

this

within 24 hours effer death To the Funeral Director: A completely filled in by the f

death.

6

Hospital

Examiner

Physician/Medical

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Completed

8

Certification: To

Medical

aitimore, Maryland 21215-0020

Director

Funeral

P

Completed

8

19a. Informant's Name/Relationship (Type, Print) Cynthia R. Fair (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1012 Rosemont Drive, Joppa, Maryland 21085

20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/26/99 Baltimore, Maryland Holly Hill Mem. Gardens 22. Name and Address of Facility

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Dete

Immediate Cause (Final disease or condition resulting in death)

a. Mulhple Ogan Dystruction Syndrome
Due to (or as a consequence of):

one week

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Sepsis Due to (or as a consequence of): Motor Vehicle Collision Due to (or as a consequence of):

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 No 2 No

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

28a. Date of tnjury (Month, Day Year) 5 Pending 07,11,99 investigation 6 ☐ Could not be

28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 7:00pM

28d. Describe how injury occurred motorcylle accident

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5 treet - Roule 1 - Hartord County 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Harford

(Check only one)

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier Was The MA

D 24285

1979

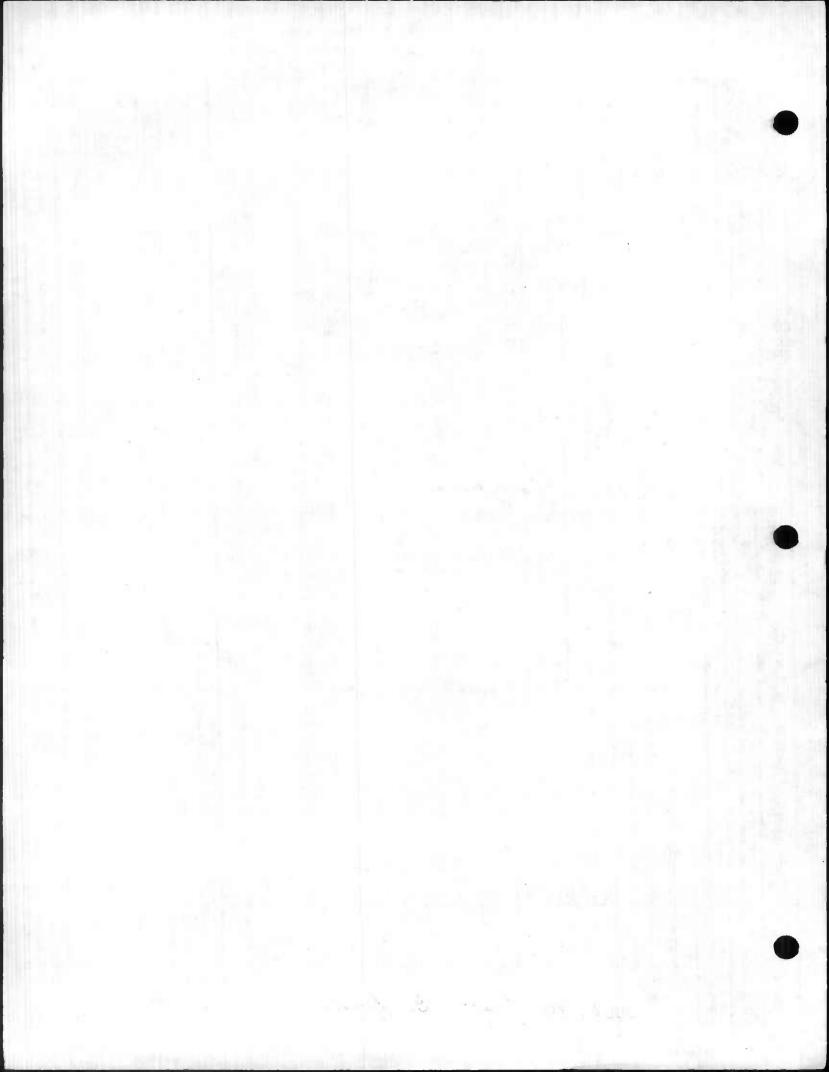
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debra L. Malone

of Maryland Medical System University 32/Registrar's Signature

22 Greene Street Baltmanes mb

State Registrar

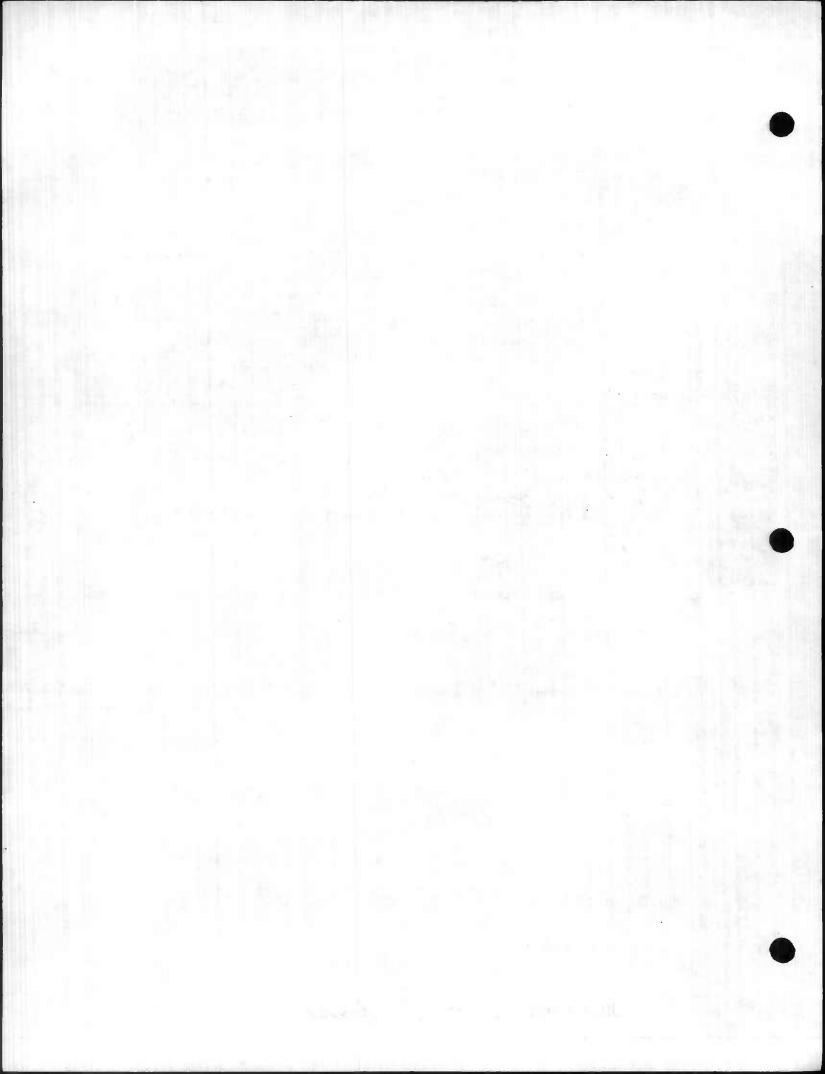
31. Date filed (Month, Day, Year)
JUL 2 7 1999 DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** CHARLES GUNTHER 1999 10:21 PM JULY 23 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaratian Hosp Baltimore M Under 24 Hrs. | 8 Day 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sax 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXM 20 F Min. Months Hours Days Yrs. 43 Director 213-70-1513 Apr. 13,56 Maryland the Maryland 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Nems 23s or 28a-f show traumatic event, the Medical Examiner must be notified at Harford BelAir 1 ☐ Yea 2 No Director Md. 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 649 Carleton Trail 21014 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Wea Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Meritel Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene.
Int: If them 27 is marked other than "natural", or her 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1□ Yes 25 No Specify: SpecifyWhite þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Rusiness/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Construction Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 10 Leanora M. Gately Frederick Gunther 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 649 Carleton Trail, BelAir, Md. 21014 Leanora Gunther / Mother other 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) injury or permit. Page Department of Important: If any injury or Balto-Wash. Crematory 7-26-99 Laural, Md. 108422. Name end Address of Facility 21. Signature-of, Funeral Service License Bradley-Ashton-Matthews Funeral Home, Inc. 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) ENDOCAR DI TIS Examiner Due to (or as a consequence of) Examiner siclan and burial-transit HEMIDRAHAGIC Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buries Box 68760 DA Physician/Medical Due to (or as a consequence of): US. Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 785 certificate 1 Yes ZENO 1 Yes 28 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No L_o 1√2 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 26d. Describe how Injury occurred Ne Hospital or Attending P n 24 hours after death. Certification: 28c. Injury at Work? After 1/ Natural 2 Accident 5 Panding investigation 1□ Yes 2□No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23, 1999 MONA SMBRA. JULY 11 P11390 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) SABRA COCH 5601 BALTINOVE RAVEN SLUD 31. Date filed (Month, Day, 32. Registrar's Signature State 1999 Registrar

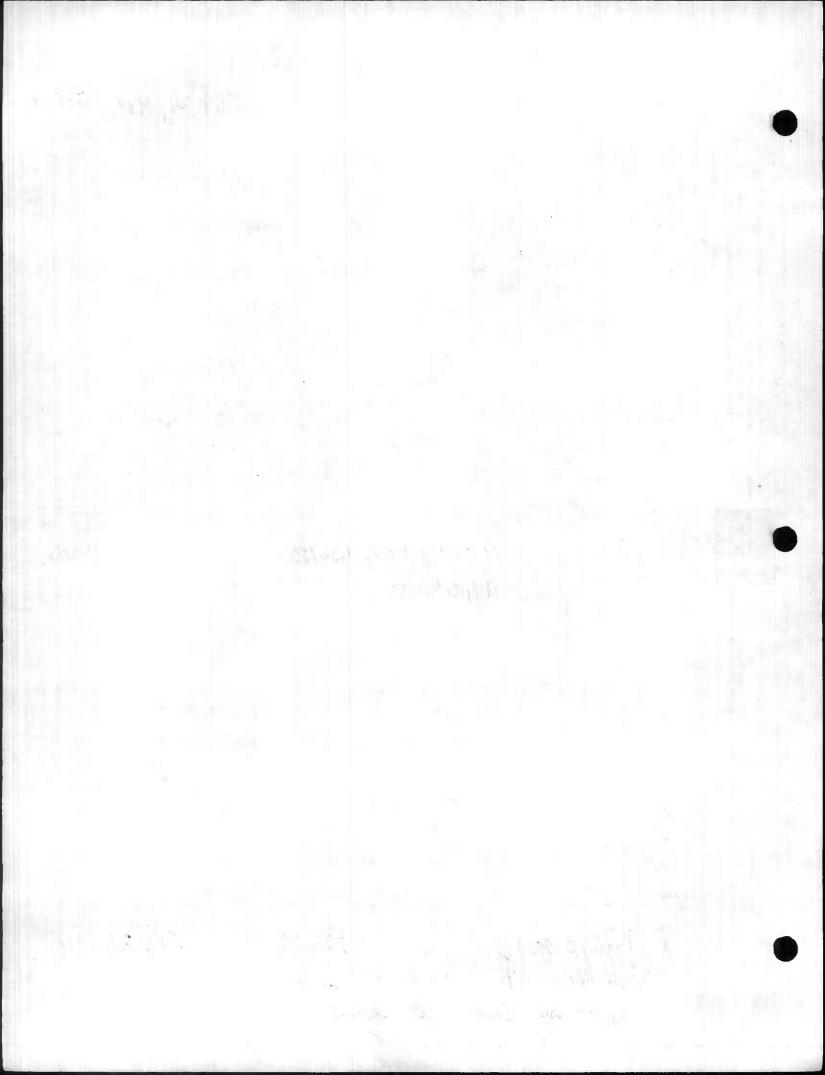


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State of Maryland / Department of Health and Mental Hygiene 99 23601

				Certif	ficate of	Death			Reg. No.		_0001	
Physician	Decedent's Neme (First, Middle STANLEY	JOSEPH	GI	RYSIK	IEWICZ			2. Date of De	29° 19	ğğ	3. Time of Death 8:35 AM	
/Medicals Examiner	4a Facility Name (If not institution							cation of Deat				
Funeral Director	1123 COLONY RII 5. Social Security Number 102–16–2428		ge (In yrs. last bii 85		f Under 1 Yaar fonths Days			8. Date of Bir (Month, Da JUNE	th y, Year)		RUNDEL place (State or Foreign intry) YORK	
D .	Usuat Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Locati	ion			OONE	.5, 1514		10d. Inside City Limita 1 ☐ Yes 🏋 ☐ No	
vith the Me tor 28e-f e	MARYLAND ANNE 10e. Street and Number	ARUNDEL			DENTON 10f. Zip Code		-		10g. Citizen of V	Vhat Cou		
th with 23a or all Dis	1123 COLONY RI	OGE ROAD			·	1113				.S.A		
or the sample by Fur	11. Marital Status 1 Never Married 2 Merr 3 Ø Widowed 4 Divorced		Evarin U,S. No 1942- 1946- 1950-65	If Ye	s Decedent of I es, specify Cub Yes XX No	an, Mexicar	gin? (Spe n, Puerto I	cify Yas or No Rican, etc.)		k, White,	ican Indian, , atc. HITE	
	15. Deceden (Specify only higher Elementary/Secondary (0-12) 1.2	ra Education	16a. 5+)	Decedent	t'a Usuel Occu d of work done NOT use retire	pation during mos	t of workin	ng	16b. Kind of Bu		iduatry	
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1 and 2 sho Heelth end em 27 la m ither traum	19a. Informant'a Neme/Relations MICHAEL GRYSIK								er, City or Town, FLORID			
Semit. Pages 1 separation of He mportant: If them iny injury or other store.				ry, cremete	ory or other ple		1	8/3/99 Y	20c. Location -			
permit. Peg Department Important: I any Injury o	1 M Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) ARLINGTON NATIONAL CEMETERY FORT MYES 22. Name and Address of Facility SINGLETON FUNERAL F SECOND AVENUE, S.W., GLEN BURNII 23a. Part Lenter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List may one cause on each line.											
Addical Examiner Medical Examiner Medical Examiner	Immediate Cause (Final diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a Due to (or as a Due to (or as a Due to (or as a decorate or a decorate or a decorate	atte consequent SION consequen	My dis-						Approximate Intervet Between Onset and Death Grant Strain S	
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on that gened by be deta by Pt								10	Yea 22 No	3 Pro	obably 4 Unknow	
aw requ							_	24a. Was perfo	an autopay rmed?	a	Vere autopsy findings vailable prior to ompletion of cause of death?	
Fad								10	/	1	☐ Yes 2☐ No	
	25. Was case refarred to medical axaptiner? 1 2 Yes, 2 No	Hospitel:	ient 2 ☐ ER/Ou	itnationt	3□ DOA Ot	her		na 510 Back	one) dence 6 □Oth	er /Snec	ih)	
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tal or Attending P as after death. al Director: After ted in by the funers Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 289. PIECE OF IT	njury - At home, la vic. (Specify)	ım, street,	, fectory, office		2	281. Location (City or To	Street and Numb vn, State)	er or Rui	ral Route Number,	
To the Hospital or Attending Philipin 24 hours after destinated to the Funeral Director. After this completaly filled in by the funeral Medical Certification: 7	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the best Examiner: On the basis of and manners	of examination an	e, deeth oc d/or invest	courred at the ti	ime, date an opinion, dee	d place, a th occurre	and due to the ed at the time,	cause(s) and me date and place,	and due	stated. to the cause(s)	
To the transfer of the transfe	29b. Signeture and title of certifier	rugge MD			29c. Licen.	8640)		July	24	, Day, Year) , 1999	
	30. Name and edities of person	who completed cause of	Crofi	Type, Prir	y 2	1114	SKIGG	ss, M.D	. ,			
State Registrar	31. Date filed (Month, Day, Yell) JUL 27		trar's Signature	1. 19	porks	1		Y.				

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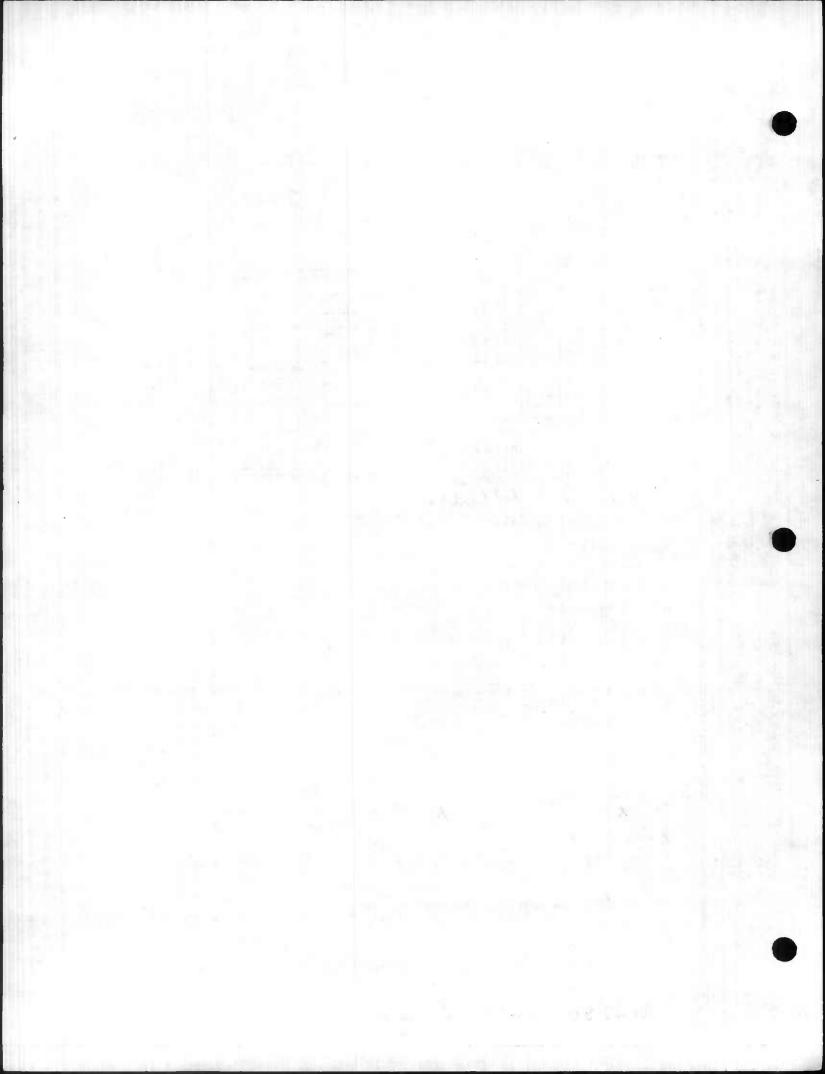
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Security Security			12. Waa Deceden	t Ever in U	I,S. 13.	Was Dece			gin? (Spe	cify Yes or No-	14. Rac	e - Americ	an Indian,
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MEADOWRIDGE MEMORIAL PARK 7/28/99 ELKRIDGE, MD.				t)		-							
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)	Sertific	determined	28e. Place of Ir building, e	njury - At h dc. <i>(Specil</i>	ome, farm, at	reet, facto	ry, office		1			oer or Ruri	il Route Number,
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Heuming Sylder MD 7 10879 JULY 24,1999.		29b. Signature and title of certifier	` ^		-	29	_				29d. Date signe	d (Month,	Day, Year)
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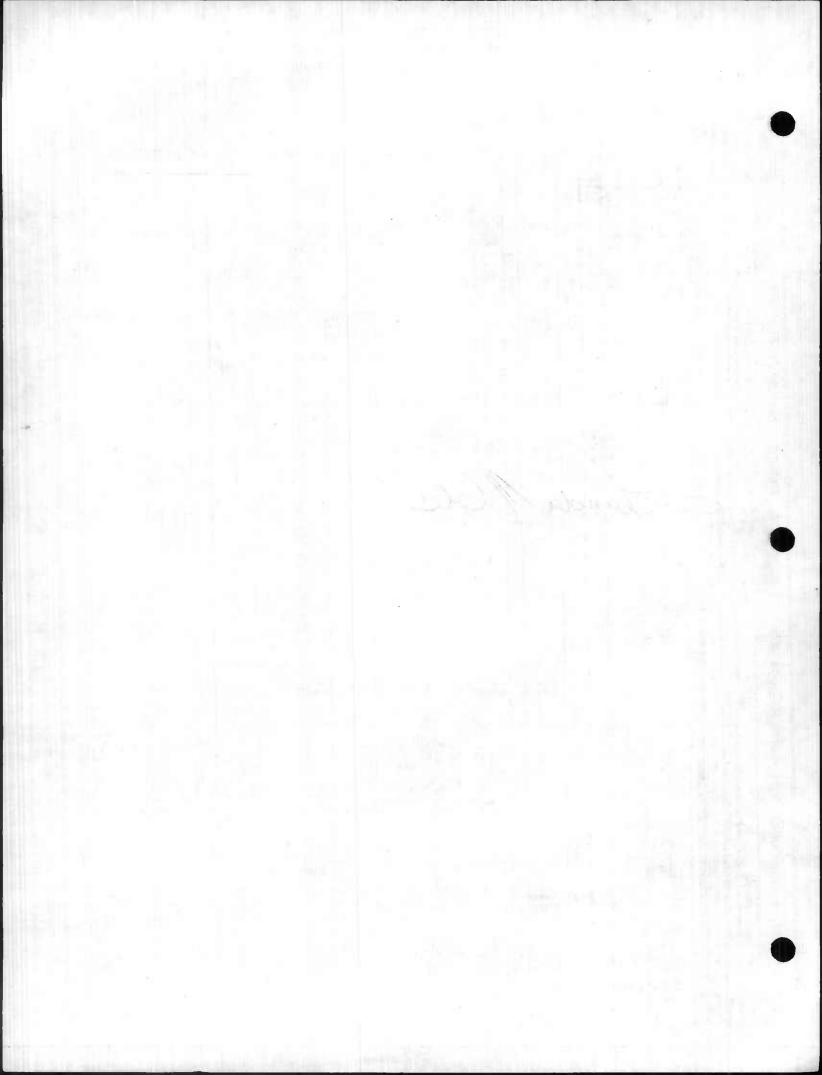
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	Funeral Director		5. Social Security Number 6. Security Number 219-94-2931 Usual Rasidence of Dacadant	x X X 2□ F	7. Age (In yrs	24 Yrs.		er 1 Yeer s Days	If Under Hours	Min.	8. Dete of Bir (Month, Da June	th 6/5/75 y, Year) 199	9. Birth Cou	place (State or Foreign intry)
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	Se-f	cto	MD		В	altin								1∏Yas 2□No
	h with th	ai Dire	10e. Street and Number 10 N. Woodingto:	n Rd.	# B1		10f. Z	ip Code 2 1	1229			USA	of What Cou	intry?
020	n 72 hours after death with the Maryland "natural", or items 23s or 28=f show edical Evansher mat be notified at	by Funeral Director	11. Meritel Status † Nevar Married 2 Merried 3 Widowed 4 Divorced	12. Was Deci Armed Fo 1 Tes If Yas, Gir Yeer or D	2 3 X X	U,S. 13		edent of Foedity Cubi	lispanic Ori an, Mexicar Specify:	gin? (Spo , Puarto	ecify Yas or No Rican, atc.)		ace - Amari lack, White city: B1	, atc.
21215-0020		Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1	1-4or 5+)	(Gi	cedent's Us ve kind of v . DO NOT	vork done	during mos	t of work	ing	16b. Kind of	Business/Ir	ndustry
	filed within Hygiene. ther than	Co	12			Fac	ctory	WOI			4577		abor	er
Maryland	Mental H Mental H mrked oth	8	17. Father's Name (First, Middle, Last)								(First, Middle,		ame)	
2	2 should and Men is marks surratic	٩	Elce Hamilton 19a. Informant's Name/Relationship (7	voe Print)		19h Ma	ilina Addra	ss (Street			Tellir		vn. Stata Zi	in Code)
	1 and 2 s Health ar em 27 is other trau	j	Lisa Hamilton	oweii	ter)	154	15 Ba	rret	t Ro	в.	alto.	Md. 2	1207	, 0000
Baltimore,	SOF		20a. Method of Disposition 1	Removal from		Place of Dis cemetery, co rylar Moria	position (Notematory of	ame of other place tion	nal	7_	Date 26-99	20c. Locatio		
alti	permit. Page Department of Important: If eny Injury or page.		21. Signature of Funeral Service Licens		30	A					al Ser			
<u> </u>	82558		Joander	///	(al	es			Nor			VICES		
	Physician /Medical Examiner	her	23a. Peri - Fater ina disaasa, or contahook, or haart failura. List only of immediate Cause (Final disaasa or condition resulting in death)								d blu		orce	Interval Between Onset and Death
	te be asscuted ysician and te bunal-transit	cal Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Causa (Diseese or Injury	b. ———	Dua to	or as a cons	sequence of	r):						
x 68760,	r requires that the death certificate be associted been signed by the attending physician and should be detached for use as the bunat-transit	-	causa. Entar Undarrying Causa (Diseese or Injury that initiated events rasulting in death) Last	C	Dua to (or as a cons	equence of):						
Boo	attend for us	clan/		G									1	
P.O.	requires that the death certifical seen signed by the attending phy hould be detached for use as the	/ Physician/Med	Part II. Other algnificant conditions co	ntributing to de	eath but not ra	sulting In tha	underlying	causa giv	ven in Part i		23b. Did	~		to the cause of death? obably 4 Unknown
Records, P.O. Box	S 8 0	Completed by										an autopsy rmed?	8	Vare autopsy findings vailable prior to ompletion of cause f death?
č	The law ate has b page 2 s	Con									地	Yas 2□No	1	Yes 2□ No
Division of Vital	Attending Physicien: It death. ector: After this certific by the funeral director,	Be	25. Was casa rafarred to medical examiner?	Uses hali				0.1		of Deat	(Check only	one)		
of	Physic this o	-T	1)∑ Yes 2 No 27. Mannar of Death	Hospitel: 1 🔲		ER/Outpat			4LINU		ma 5 Rasi		uerod	W) SCENE
o	ding the After	Certification:	1 □Natural 5 □ Pending		th, Day Year)	Injury	- M	28c. Injur Wor	k? Yas 2.⊠		Subject	was.	shot	and struck
/ISI	Attendir death.	fica	3 Suicide 6 ☐ Could not be	28a. Place	of injury - At I	OOO noma, farm,	0		Die Tex		28f. Location (Dlunt Street and Nu	mber or Ru	ral Route Number.
á	s after	Cert	4 2 Homicida Gatermined	buildi	ng, alc. (Spec	3				6	Saltimor	-0.0	5. K	rooding ton
	To the Hospital or Attending Physicien: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifler (Check only one)	ner: On tha bi	best of my kn	owiedga, da				d place,	and due to tha	cause(s) and		
	To the To the	Me	29b. Signatura and titla of certifier		1	1	2	9c. Licens	e number			29d. Dete sig	ned (Month	, Day, Year)
			30. Name and address of person who c	1/L	a of death (Ite	123a) ITVI	MP	O.C.1	M.E			JULY 20	, 1999)
			Stephen S. 1	Lade				1 Per	nn Sti	ceet,	Balti	more, M	Maryla	and 21201
	Sta Registr		31. Data filed (Month, Day, Year)	Server 32. R	egistrer's Sign	nature								

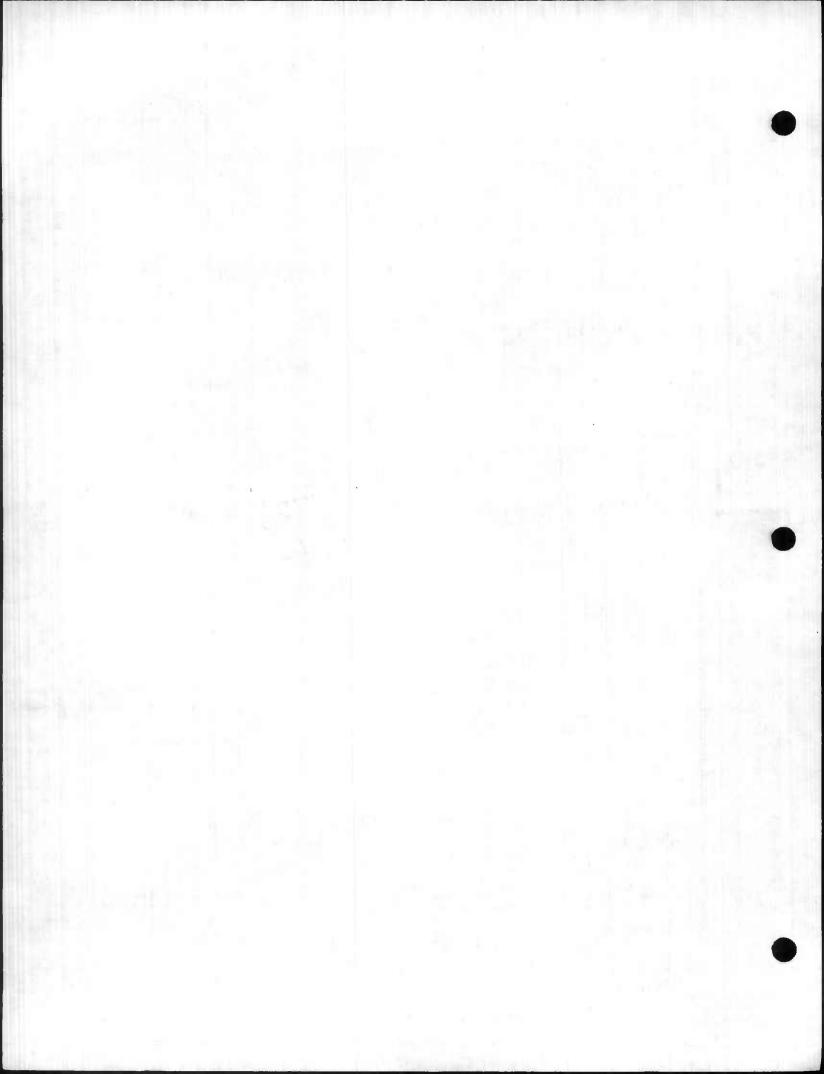


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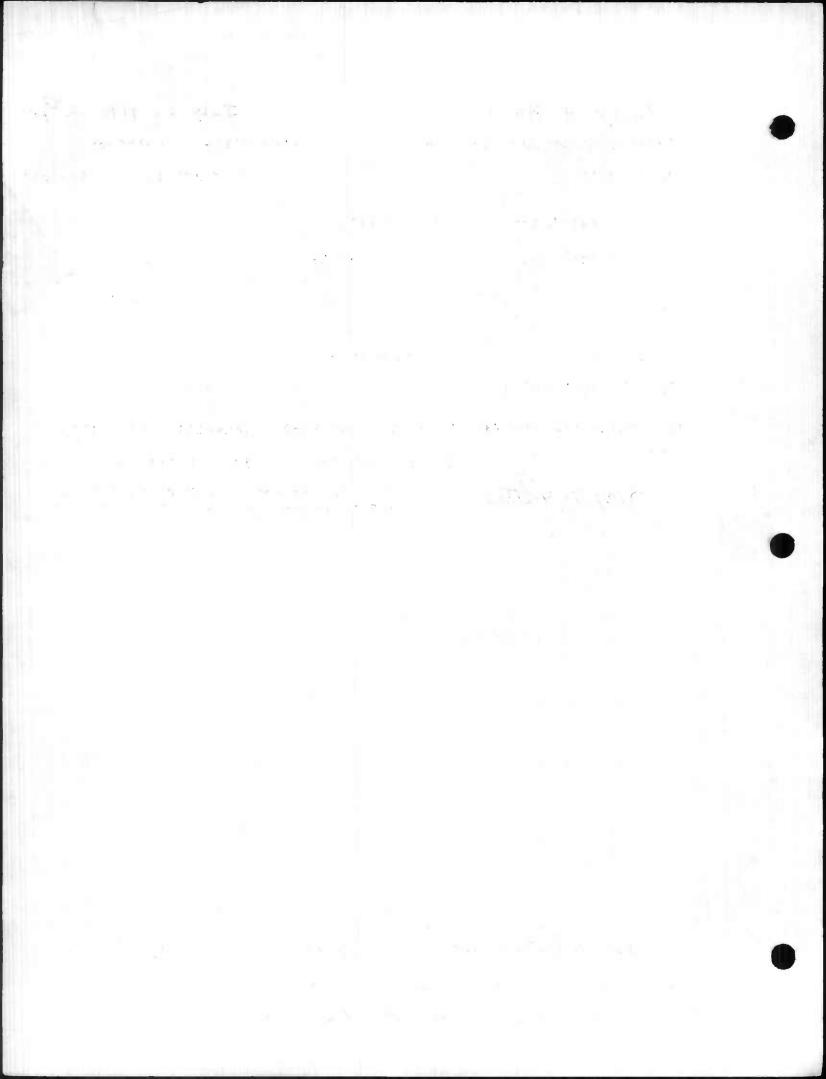
					Cei	rtifica	te of	Death			Reg. No.			
		1. Decedent's Name (First, Middle, La	nst)					_		2. Date of De		V	3. Tim	ne of Death
Physicia /Medic		VIOLA KEHNE HAMEL	LIN							July 2	3. 199	9 Year	8:1	15 a.m.
Examine		4a Facility Nama (If not institution, gir	ve street and number,)				4b. City, To	wn, or Li	ocation of Deat		nty of Death		
		Mariner Health of	Forest H.	ill				Fores.	t Hi	ll	Har	ford		
Funeral Director		5. Social Security Number 6.	Sex 7. A	ge (In yrs. las	t birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De NOV . 2			place (Stanty) U.C.A.N.(ate or Foreign
		Usuel Residence of Decedent									, , , , , ,		,	
Maryland -f ehow	tor	10a. State 10b. County Maryland Harfor	d	10c. City, T	own or Lo							1		te City Limits
5 P	Director	10e. Street and Number	<u> </u>	10,00	S.C. 11.	-	p Code			T	10g. Citizen o	of What Cour	ntry?	
23a or	ral D	315 Bynum Ridge	Road				050				U.S.A.			
0 =	by Funeral	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces' 1 Yes 2 X If Yes, Give Yeer or Detes:	?		Wes Deco If Yes, sp 1 ☐ Yes	ecify Cub	lispanic Ori an, Mexicar Specify:	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)		tace - Americ Black, White, city: W/		n,
d within 72 hours af	Completed	15. Decedent's E (Specify only highest gr		1	8a. Dece	dent's Us	ual Occup ork done	pation during mos d)	t of work	ing	16b. Kind of	Business/In	dustry	
d withir gione.	ошо	Elementery/Secondary (0-12) 8th grade	College (1-4or	5+)	Home			a)			Own t	lome		
2 2 2 2	To Be C	17. Fathar's Name (First, Middle, Last Henry Kehne	1)							e (First, Middle Steinro		ame)		
D = 1.		19a. Informant's Name/Relationship (Ruth Maddox (Dau								Fores.			210	50
		20a. Method of Disposition 1	Removal from State		etery, crer	matory or	other pla		1	Date 7/26/9	20c. Location Balt	,		
permit. Page Department of Important: If any Injury or place.		21. Signature of Funeral Service Libensee 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Road,									Bel A	ir, Ir	nc. 2101	1.1
	1	23a. Part1. Enter the disease, of conshock, or heart failure. List priy		d the death. I	Do not ent	er the mo	de of dyi	ng, such as	cardiac	or respiratory a	rrest,	MD.	Approx	imate I Between
	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b	Due to (or as	u 001304	4001000		sia					40	ay
for us		Part II. Other size Misset assetbless	d		- to Maria					004 DIA	A.L.			
that the de by the detached	Physician	Part II. Other significant conditions of		out not resultin	ng in the u	naenying	cause gr	/en in Part i	•		tobacco use Yes 2□ No			40 Unknow
8 58	Completed by	- Contragil	CICONO								an autopsy ormed?	av	vailable pi	psy findings nor to n of cause
The law ate has page 2	Ē									10	Yes 2 No		☐Yes	2∏ No
iclan: The		25. Was case referred to medical	T					OC Plans	of Doot			1	103	20140
	o Be	examiner?	Hospital:	2DED	Outnotice	nt 3 🗆 C	OA OH	or L		h (Check only		Other /Coord	Mark .	
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To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	jury - At home ic. (Specify)	, farm, str	reet, fecto	ry, office			28f, Location (City or To	Street and Nu wn, State)	mber or Run	al Route	Number,
the Hospital hin 24 hours of the Funeral hpletely filled	edical		nyaician: To the best miner: On the basis o and manner st	examination										use(s)
Withir To the Comp		29b. Signeture end title of certifier		^		29	c. Licens	se number		T	29d. Date sig	ned (Month,	Day, Ye	er)
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		30. Name and address of person who AUN MCClue	и		61		Mac	Phail	Roa	d, Bel	Air,	MD. 2	21014	4
State Registra	-	31. Date filed (Month, Day, Year)	Server 32. Registr	rar's Signature	1									



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tate of Maryland / Department of Health and Mental Hygi	iene	99	2	3	6	0	6
Certificate of Death	g. No.						

					$C\epsilon$	ertificate	of	Death		R	leg. No.		
Dhusisia		1. Decedent's Neme (First, Middle,	Last)							2, Date of Dea Month	th Dey	Year	3. Tima of Death
Physicia /Medic		Lucy H.	Hau	•						July	23	1999	2-pm
Examine		4a. Facility Neme (If not Institution,	give street and n	umber)				4b. City, To	wn, or Lo	cation of Death	4c. Coun	ty of Death	1
		Ridgeway Mano:	r Nursi	ng Ho	me			Cat	onst	rille	Bal	Ltimo	re
Funeral		5. Social Security Number	B. Sex	7. Age (In y	rs. last birthday) If Under 1 Months	Yeer Days	If Under	24 Hrs. Min.	8. Dete of Birth (Month, Day	Vear	9. Birthp	place (Stete or Foreign
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ahon ahon da an	_				City, Town or L							1	1 ☑ Yas 2 ☐ No
M P P	oct		imore		Catons								
Taily fail of a Late 12-000.00 and the Maryland 2 should be filed within 72 hours after death with the Maryland 2 should be filed within "natural", or frema 28a or 28a-1 show raumatic event, the Medical Examinet must be notified at	Director	10e. Street and Number				10f. Zip C	ode			1	0g. Citizen of	What Cour	ntry?
23a	<u>rai</u>	236 Blakeney	Road				22				USA		
tem tem	Funerai	11. Meritei Stetus	Armed F	cedent Ever in Forces?	U,S. 13.	Was Deceder	nt of H	lispenic Origan, Mexican	gin? (Spe	cify Yes or No- Rican, etc.)		ice - Americack, White,	
d 2 should be filed within 72 hours after than Mental Hygiene. 7 is marked other than "netural", or it traumatic event, the Medical Example.	by F	1 Never Married 2 Marrie	If Yes, G			1 ☐ Yes 2	Mo	Specify:			Spec	whit	е
ural'		3₺ Widowed 4 Divorced	Year or	Dates:							1 330		
nate roller	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual e kind of work	done	during most	t of worki	ing	16b. Kind of	Business/In	dustry
within	ם	Elementary/Secondary (0-12)	College	(1-4or 5+)	1	DO NOT use		a)					
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", eny Injury or other traumatic evant, the Medical East once.	ı	21. Signature of Funeral Service Li	censee	-)		2. Neme end				Schwah	Euro		h - m -
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		23a. Parti. Enter the disease, or c	omplications that	caused the de	ath. Do not er	nter the mode	of dyle	ng, such ss	cardiac c	or respiratory arr	est,	MI	Approximate Interval Between
Physician	1				/								Onset and Death
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eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if say leading to immediate Due to (or es a consequence of):											
Sian s		if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of):											
the the	edicai	that initiated events resulting in death) Lest	0.	Due to	(or es e conse	quenca of):						1	
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The law requires that the death of the has been signed by the attendage 2 should be detached for us	Physician	`	- u										
that the death c	sic	Part II. Other significant condition	s contributing to	death but not r	esulting in the	underlying cau	se giv	en in Part I.		23b. Did to	obacco use c	ontribute te	o the cause of death?
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has be	Die											of	mpletion of cause death?
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Attanding Physician: r death. ector: After this certifice by the funeral director.	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 [Inpatient 2	☐ ER/Outpatie	nt 3□ DOA	Oth	105		me 5 Reside		ther (Specif	(v)
g Phys er this seral di	2	27. Manner of Deeth		of Injury nth, Day Year)	· · · · · · · · · · · · · · · · · · ·		: Injur Wor			28d. Describe h			,,
ath.	Certification:	1 ☑NetursI 5 ☐ Pending 2 ☐ Accident investiga		nin, Day rear)	Injury	М		Yes 2□	No				
Atta or de by th		3 ☐ Suicide 6 ☐ Could no determin	Ar 200, FIBL	e of Injury - At	home, farm, s	treet, factory, o	office		- 1	28f. Location (S	treet and Nun	ber or Rurs	I Route Number,
o affe	e l	4 D HOITICIDE	Duik	ding, etc. <i>(Spe</i>	ciry)					City or Town	n, State)		
To the Hospital or Atlanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ht completely filled in by the funeral director, page	ië	29a. Certifier 1□ Certifying	Physicisn: To th	e best of my k	nowledge, dea	th occurred st	the tir	ne, date an	d plece, e	end due to the c	ause(s) and n	nannersss	tsted.
n 24 n 24 ne Fu	edicai	(Check only 2 Medical Ex	raminer: On the I and ma	basis of exami nner stated.	nation and/or is	nvestigation, in	my o	pinion, deal	th occurre	ed at the time, d	ate and place	, and due to	o the cause(s)
Withi To the	Σ	29b. Signeture and title of certifier				29c. l	icens	e number		2	9d. Date sign	ed (Month,	Day, Year)
		Denles R. Greden fr m.o. 024781 July									July	252	1999
	ŀ	30. Name and address of person w	no completed cau	ise of death (It	em 23a) (Type	Print)					0		
		OMARLES R. GRM	the one n	0. 100	1 PINC	Wight	7 A	re s.	300	Barres	ec, no	2122	-8
State		OHARLES R. GRAM 31. Dete filed (Month, Day, Year) JUL 2	32.	Registrar's Sig	nature				- (- '	*		/
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Physician HARRIS HELEN LUVISE 1999 9:25 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1010 W. BALHMOR STREET BALTIMOR Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 28 F Months 217-18-0816 75 marylans Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at BALHOUCE Pares 2 No Director Haryloso 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with STYEEL 21223 1010 W. BAHIHOR 05A 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22000 If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yea or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11 Marital Status permit. Pages 1 and 2 ahould be filed within 72 hours effect. Department of Health and Mental Hyglens. Important: if item 27 is marked other than "natural", or hen eny injury or other traumatic avent, the Medical Especia Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Black P Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME Housewife 12 th grade 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) B. Parline Montgumery VERMELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/7 19a. Informant's Name/Relationship (Type, Print) 631 N. SCHROEDER STREET BALLIMOR. DIAME HARRIS / DAUghkar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition LUUMS VILLE VETERANS CENTRY 12 Burial 2 Cremation 3 Removal from State Crownsville, Mel 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHA THIM - HARRY FURROL HONG 21. Signature of Funeral Service Licepsee 5240 KUSTERIHUND KUMO Gari BALHMUIL, Mary lano 21218 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner vascular dixax Physician/Medical Examiner physicien and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 68760 Due to (or as a consequence of): US0 88 Box P.O. 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TOTOR 2 No 3 Probably 4 Unknown Records, ğ 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to Completed completion of cause of death? M4 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) CALO HOMO edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred NA 28b. Time of 28c. Injury at Work? After Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, term, atreet, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hosp within 24 hor To the Fune completely fil

State

(Check only one)

30. Name and all

29b. Signature and title of contifier

31. Date filed (Month, Day, Year)

about

Registrar DHMH 16 Rev 6/95

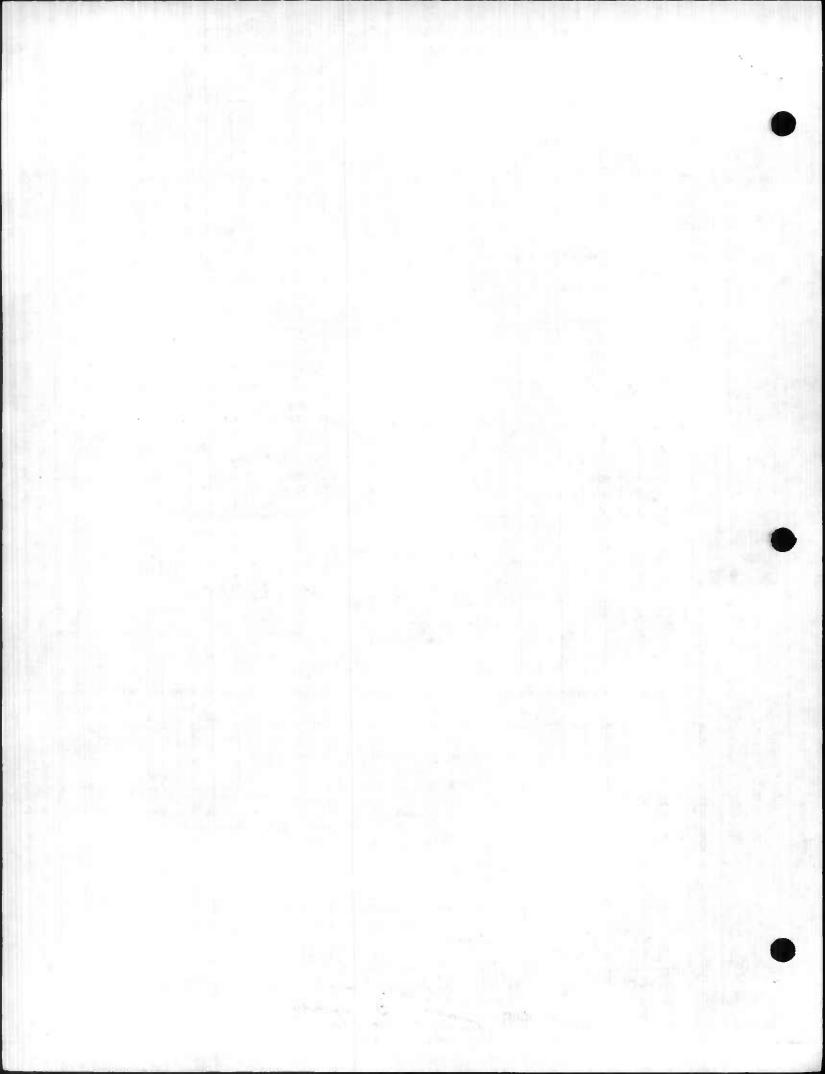
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dress of person who completed cause of death (Item 23s) (Type, Print) 10

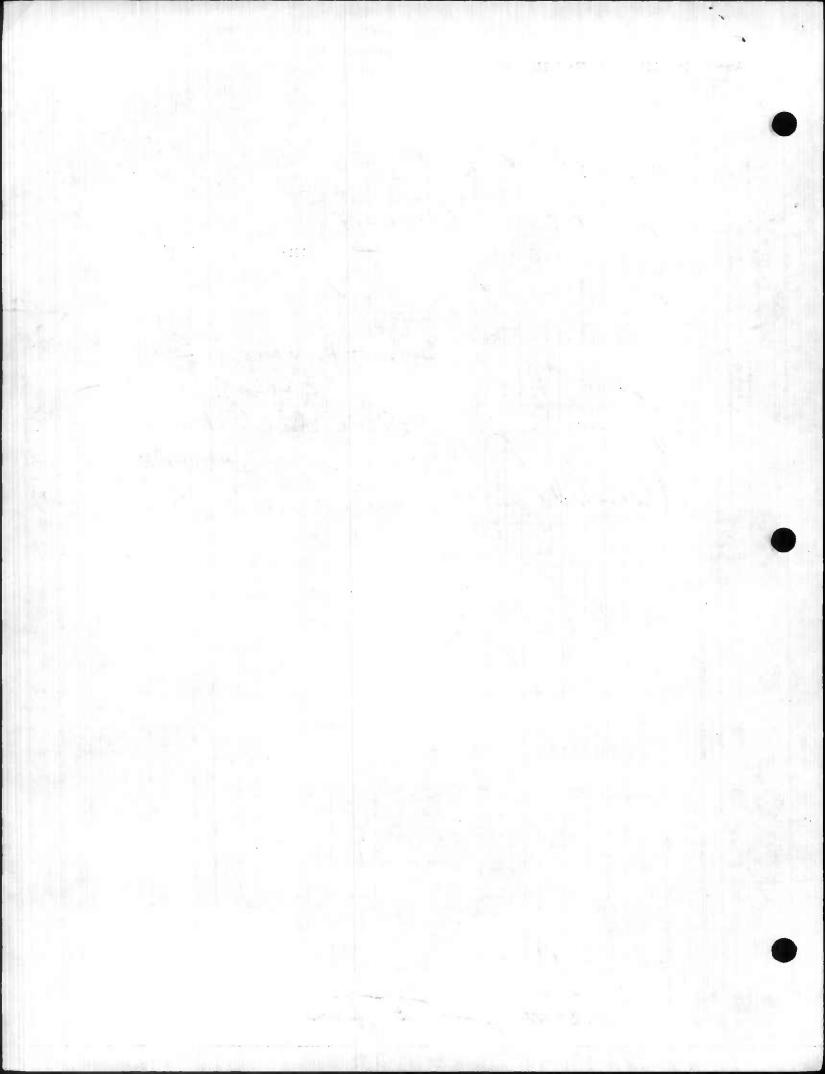
32. Registrac's Signature

29c. License number

29d. Date signed (Month, Day, Year)



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	Amende	ed	Item#106 perFH G773 7/2			ficate of			Reg. No.	200	000
	Physicia		1. Decedent's Nama (First, Middle, Last	0		Ho	irt	2. Date of De Month	Day	Mana	Tima of Death 3:08 PA
	/Medica Examine	_	4a Facility Nama (If not institution, give	street and number)			4b. City, Town, or	Location of Deat	- /		
	Funeral Director		000000000000000000000000000000000000000			If Under 1 Yes Months Day		s. 8. Data of Bir	th y, Year) 21 1929	9. Birthplace Country)	(State or Foreign
	Maryland -f ahow	tor	Usual Residence of Decedent 10a. State 10b. County MARY And N	10c. 0	N. Town or Local	tion RF			,		nsida City Limits
	th with the 23a or 28a at be not	al Directo	10e. Street and Number	E Street		101. Pp Code	21213		10g. Citizen of	What Country?	
020	urs s	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:	N Y	S Decedent of es, specify Cu Yes 2 2 N	Hispanic Origin? (upan, Mexican, Pue o <i>Specify:</i>	Specify Yas or No rto Rican, etc.)	14. Rac Bla Specify	ce - American Ir ck, White, etc.	ndian,
21215-0020	within 72 ho	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Deceden (Giva kin lifa. DO	of work don	ne during most of w	orking	16b. Kind of B	usinass/Industr	ospital
Maryland 2	tal Hygi d other event,	o Be Co	17. Father's Name (First, Middle, Last)	Allen	Jugov.	01.7	18. Mother's No	ame (First, Middle	Maiden Suman	na).7	
Mary	d 2 sho th and N 7 is ma treums		19a. Informant's Name/Relationship (7)	ype, Print)	19b. Meiling	Address (Stre	et and Number or F	Rural Royta Numb		a mal	2/124
altimore,	Pages 1 and nent of Health int: If Nem 27 iry or other to		20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State Q	Place of Dispositi	ion (Name of lory or other of	Pape)	Data 7/20/00	20c. Location	Otty or Town,	Stata
Baltir	permit. Pag Department Important: eny Injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Closes		1 122	lama and Add	Irase of Facility	Jones,	JE. H	more H.	PA.
	Dia de la la la la la la la la la la la la la		23a. Part1. Enter the disease, or comp shock, or heart lailure. List only o	lications that dused the dea ne cause on each line.	th. Do not entar	tha mode of d	lying, such as cardin	ac or raspiratory a	rrast,	Inte	proximate erval Between set and Death
	Physician /Medical Examiner		Immediata Causa (Final disease or condition resulting in death)		epsis					7.	H hrs.
	ъ т	je l		Box	vel fo	tarch	ion			2	4 hrs.
o`	be asseuted sician and buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	A	heroso	1				2	years
09/89 X	death certificate be e ettending physicia ed for usa as tha bu	Medical	Cause (Disease or injury that initiated events resulting in death) Last		or as a conseque	7 L TV 11	ſ				ylars
P.O. Box	v requires that the death certificate been signed by the ettending phys should be detached for usa as tha	Physician	Part II. Other significant conditions con	ntributing to death but not res	sulting in the unde	ertying causa (given in Part I.		lobacco use co Yea 22 No		cause of death?
Hecords,	law requires that the as been signed by the 2 should be detache	Completed by Physician/Medic							an autopsy ormed?	availab	utopsy findings le prior to stion of cause h?
_	sicien: The law certificate has b lirector, page 2 s	E OS						10	Ves 25/10	1 ☐ Ye	s 2₽No
r vital	Physicien: this certific ral director,	0 0	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 18 Inpatient 2	ER/Outpatient	3 DOA	Whor	eath (Check only of Homa 5 Rasi		nar (Specify)	
on or	Attending Physic death. ector: After this by the funeral d		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28e. Data of Injury (Month, Day Year)	28b. Tima of Injury		jury et /ork? □ Yas 2 □ No	28d. Describe	how injury occur	rred	
DIVISION	To the Hospital or Attending Physiciem: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director,	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of injury - At h building, etc. (Speci		t, factory, offic	20	28f. Location (City or To	Street and Numb wn, Stata)	ber or Rural Ro	uta Number,
	e Hospit 24 hour e Funera lietely fills	edical	29a. Certifier (Check only one) 1 Certifying Physical Exami	eiclan: To the best of my knoner: On the basis of axamina and manner stated.	owledge, death or ation and/or inves	ccurred at the tigation, in my	time, data and place opinion, death occ	ce, and due to the curred at the tima,	cause(s) and m dete and place,	annar as stated and due to tha	f. cause(s)
	within Toth comp	M	29b. Signature and little of certifier	Mrs Villian	70		snse number		29d. Date signe	2419	
			30. Name and address of person who or Rubers M.W. Ilving To				Idinare, r	70 212	/	,,,,,	

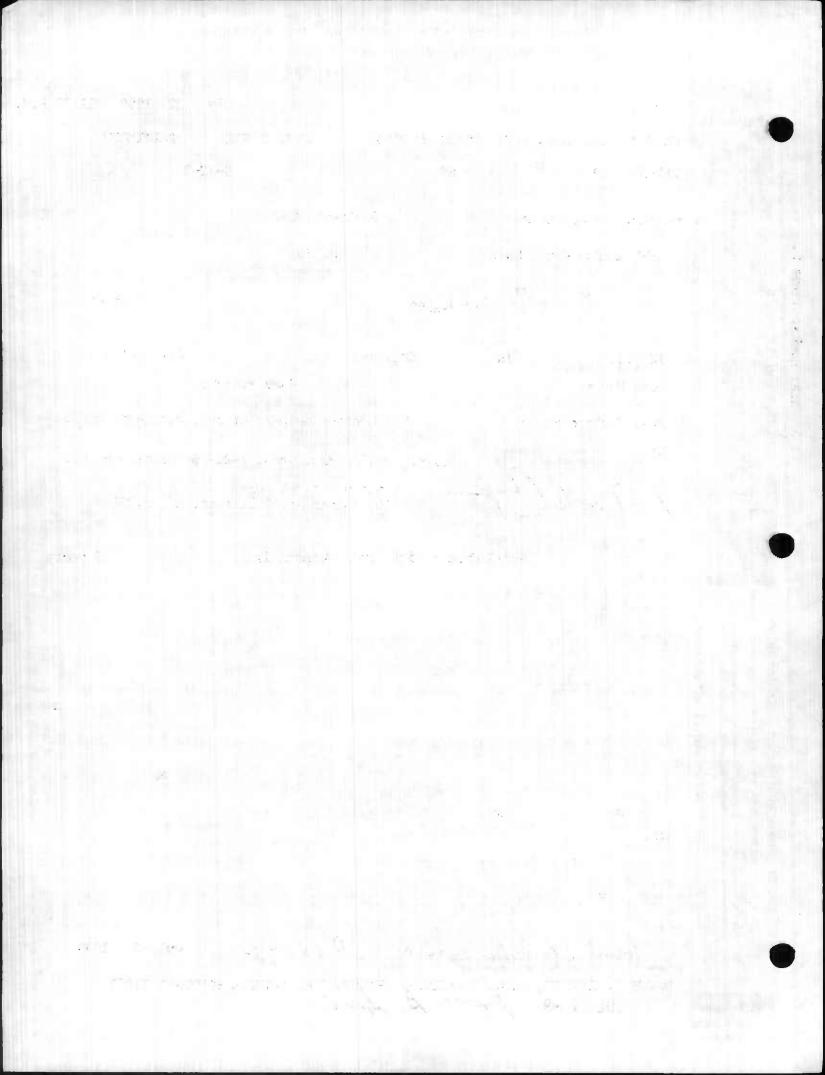


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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) _Month July 1999 **Physician** 11:30 P.M. **JAMES** HAWKS Τ. /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, giva street and number) 4c. County of Death Examiner VA MEDICAL CENTER, FORT HOWARD MD 21052 FORT HOWARD BALTIMORE If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F 69 Yrs 219-32-5829 Director PA Usual Rasidance of Decedent the Maryland 10a. Stata 10c. City, Town or Location 10d. inside City Limits 10b. County 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Modical Examinar must be nouried at 1 ☐ Yes X ☐ No Baltimore County Directo Baltimore Maryland 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number with 21236 USA 3901 Hannon Court Unit E r death Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. filed within 72 hours efter NV Yes 2 No NY Yas, Giva Yeer or Date 1948-1952 1 ☐ Naver Married 2 ☐ Merried 1 ☐ Yas XX No Specify: Specify: White PV 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Glva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Hygiene. 12 VTS 17. Fether's Neme (First, Middle, Last) Bell Atlantic Engineer N/A 18. Mother's Name (First, Middla, Maidan Surname) Peges 1 and 2 should be fill ment of Heelth and Mental H lant: If Item 27 is marked out Be Rose McGeehan John Hawks 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3901 Hannon Court Baltimore, Maryland 21236 Mrs. Marlene Hawks 20b. Placa of Disposition (Nama of camatary, crametory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition permit. Peges Department of Important: If Its any Injury or o 1XXBurial 2 Crametion 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Grdn. 7-26-99 Baltimore, Md. 21. Signature of Funaral Sarvica Ligensea 22. Neme end Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 har tha least, one course on each line. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one course on each line. Approximate Intarvai Batween Onsat and Deeth **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) e Renal Cancer with Brain Metastasis 5 years Examiner Due to (or as a consequence of): Examiner physician end s the burial-transit thet the death certificete be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Diseasa or Injury that initiated evants rasuiting in death) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical Dua to (or as a consequence of) 80 980 ō signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No g The lew requires 24b. Wara sutopsy findings svailable prior to completion of cause 24a. Wes an autopsy Completed certificate hes birector, pege 2 s 1 Yas 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, p 25. Was case rafarrad to medical axaminer? Be 26. Place of Death (Check only ona) To Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 No 1☑ Inpatiant 2□ ER/Outpatient 3□ DOA 27. Mennar of Death 28d. Dascribe how Injury occurred 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Neturel 5 Panding 1 Yas 2 No Investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) within 24 hours after de To the Funeral Directo completely filled in by th 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, daath occurred at the time, date and piece, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and mannar stated. 29a. Cartifiar Medicai (Check only one) 29b. Signatura and titla of cartifiar 29c. Licensa number 29d. Dete signed (Month, Day, Year) 0 und wan 30. Nama and eddrass of person who complated causa of daath (Item 23a) (Type, Print) GALICIA, L CENTER, MARCOS B. M.D. MEDICA VA FORT HOWARD, MARYLAND 32 Registrar's Signeture State

Registrar



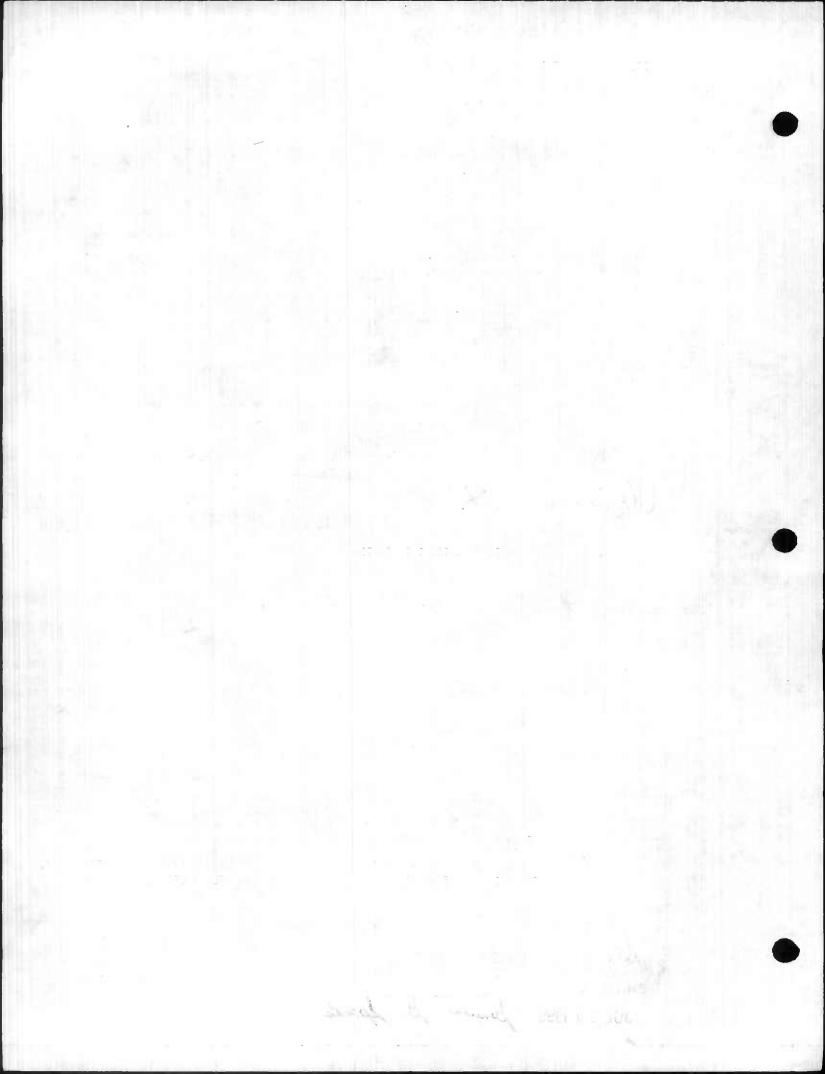
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lical		Jimmie	- 4	ner			_		July	24, 1	999		27 AM
iner		th Monfor	ve street and numbe	er)				lb. City, Town, or L		th 4c. Count	y of Death		
1	5. Social Security			Age (In vrs. i	last birthday)	If Under 1 Y	- 1	Baltimore H Under 24 Hrs.	8. Date of Bi	irth	9 Rinth	nlace (St	ate or Enreinn
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	Usuel Residence	ot Decedent 10b. County		10c. City	, Town or Lo	cation						10d Insid	le City Limits
runeral Director	MD	NA			ltimo								Yes 2□No
	10e. Street and N	lumber			201110	10f. Zip Cor	de			10g. Citizen of	What Cou	intry?	
	408 N.	Patter	son Park	Aver	nue	21	.23	31		[]	SA		
	11. Merital Stetus		12. Wes Deceder Armed Forces		S. 13.			ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or N Rican, etc.)		ce - Ameri		n,
		rried 2 Merried 4 Divorced	1 Yes 2X If Yes, Give Year or Detes	No		1□ Yes 2□		Specify:	, , , , , ,		%Bla		
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-	Hube		yner					Neathe		Smi			
		Name/Relationship			19b. Meilir	ng Address (St	reet s	and Number or Rur	al Route Numi	ber, City or Town	n, State, Zi	ip Code) 2	1231
	Neathe		ner					atterso					
l	20a. Method of Di 1 DKBurial 2		Removal from Stat	CI	emetery, cren	natory or other	· plac	(9)	Date	20c. Location			
	4 Donation	5 ☐ Other (Speci	fy)	Kı				Cem. O					
	21. Signature of F	Funeral Service Lice	insee A					ss of Fecility Ba					21202
	100	lulson	U CON		IMI	M.C.Ma	rc	ch FH 11	01 E.	North	Ave	nue	
	23a. Part1. Enter	r the diseese, or con			_			THE RESERVE AND ADDRESS.					
	shock, or he	eert teilure. List only	one cause on each	ed the deeth line.	. Do not ent	er the mode of	dyin	g, such as cardiac	or respiratory	arrest,		Approx Intervel Onset	imate Between and Deeth
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32 Registrars Stonature B. Aparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Midgla, Last) Month :25An 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street Balto Nillennium If Undar 24 Hrs. 8. Date of Birth (Month, Day, If Under Yyear Birthplace (State or Foreign Country) yes. last birthday) 6. Social Security Number 6. Sex Deys 18-9876 M 2DF M9 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Baltimore 1X Yas 2 No Ma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3308 2/2/6 U. S.A Street 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indien 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married 1□ Yes 20 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16b Kind of Business/Industry 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT-usa ratired) 15. Decedent's Education (Specify only highest grade completed) Men's Elementery/Secondery (0-12) College (1-4or 5+) Presser Store NA 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Georgianna letcher Johnson 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, Stata, Zip Code) Balto, 4d 2,216 3308 Brighton Johnson-Wife Street Ethelda 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from State Johnsville 4 □ Donation 5 □ Other (Specify) Elders burg, 21. Signature of Funeral Service Licansae 4300 Wabash Luenue 23a. Pert1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Causa (Final disease or condition resulting in death) Dua to (or as a consequence ot) Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cousa (Diseesa or injury that initiated evants rasulting in daath) Last Due to (or as a consequence of) Due to (or as a consequence ot) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 → thinown 1 | Yes 2 | No 24b. Wera autopsy tindings available prior to 24a. Was an autopsy complation of cause of death? 1 Yas 212 No 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

permit. Pages Department of Important: If it eny injury or o

Physician /Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

tem 27 la marked other than "natural", or flams 23a or 28a-f ahow other traumatic avant, the Medical Examiner must be nothing at

Pages 1 and 2 should be filed within 72 hours after death nent of Health end Mental Hygiene.
Int: If item 27 is marked other than "natural", or thems 23

Saltimore, Maryland 21215-0020

with the Marylend

Examiner

Physician/Medical USB þ Completed page 2 s Be To Certification:

death certificate be axecuted ed by the e signed t has Aftar this or Attanding 24 hours after death.

Funeral Director: A filled in by

Box 68760. Division of Vital Records,

Hospital

To the Hosp within 24 ho To the Fune completely fi

Registrar

Medical

5 Panding Investigation

6 Could not be detarmined

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) 821 N. Eulaw

28e. Dete of Injury (Month, Day Year)

STRUET-

26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

2 No

28c. injury at Work?

1 Yas

29d. Data signed (Month, Day, Year)

A- AHMED M.D 31. Data tiled (Month, Day, Year)

29b. Signatura and titla ot certifia

25. Was casa ratarred to medical axaminer?

1 Yes 2 No

27. Menner of Death

1 Natural

2 Accident

3 ☐ Suicida

29e. Certifier

4 Homicida

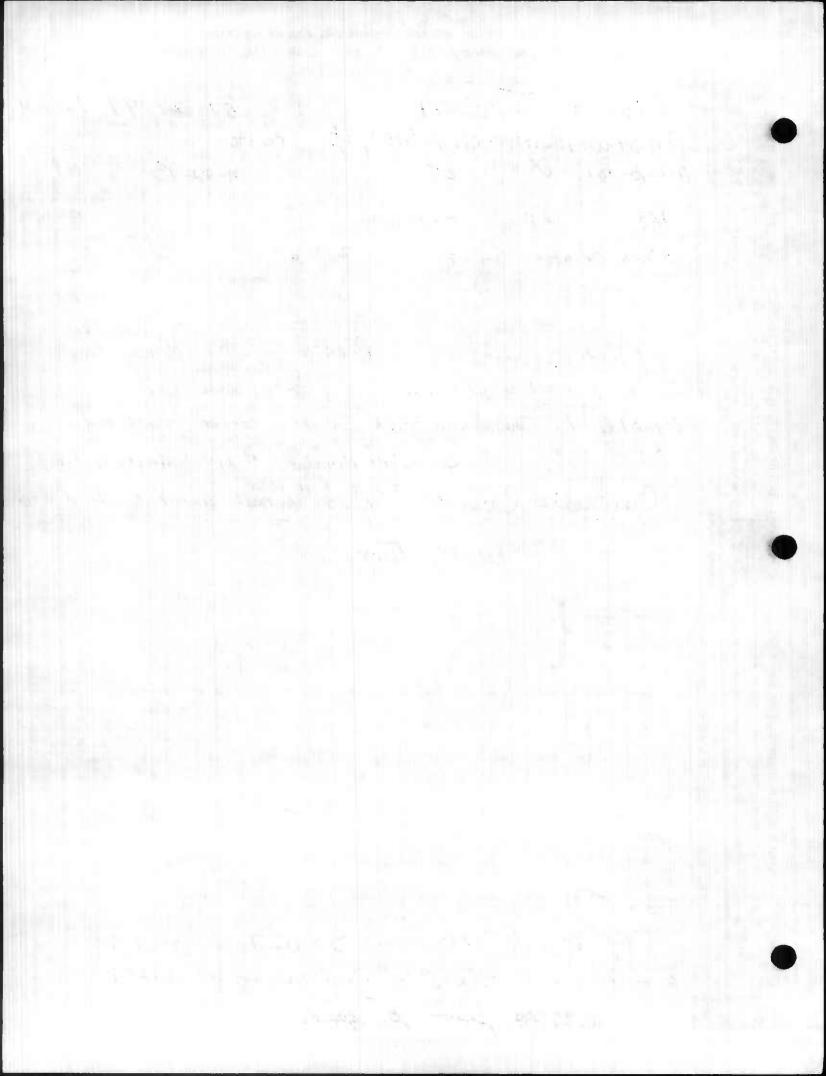
(Check only one)

32. Reğiştrar's Signature.

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At homa, farm, streat, tactory, office building, atc. (Specify)

28b. Time of



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	Funeral	Г	5. Social Security Number 6. S			Months	or 1 Year Days			Yaar)	9. Birthpla	ice (Stete or	Foreign
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	frer t	:uo	27. Mannar of Deeth 1. Natural 5 Panding	28a. Date of Injury (Month, Day Year	28b. Ti		28c. Inju Wo		28d. Describe ho	w injury occur	red		,
IVISION	eath or: A the f	cat	2 Accidant investigation			М		Yas 2□No					
2	or Att	Certification	3 Suicida 6 Could not be 4 Homlcide datamined	28a. Place of Injury - A building, etc. (Spe	t homa, fam ecify)	n, straat, facto	ry, office		28f. Location (Si City or Town	raet and Numb n, Steta)	er or Rural I	Routa Numb	er,
2	urs a urs a liled												
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	29a. Cartifiar 1★ Certifying Phy (Check only 2 Medical Examone)	valcian: To the best of my liner: On the basis of exam	mowledge, ination and/	daeth occurred or invastigatio	det tha ti n, in my	ma, data and plac opinion, death occ	e, and due to tha co urred et the time, d	ausa(s) and ma ate and placa,	and dua to t	ed. ha causa(s)	
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Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23h. Did tobacco use odniribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Pres 2 No

25. Was case referred to medical examiner? 1⊠ Yes 2□ No

5 Pending investigation

6 Could not be datamined

Hospital:

2 ER/Outpatient 3 DOA 1XX npatient 28b. Time of 28a. Deta of Injury (Month, Day Year) 19 99 15 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work? 2 No 1 Yes

28d. Describe how injury occurred

woice drowhed 28f. Location (Street and Number or Rural Routa Number City or Town, State)

29a. Cartifier (Check only one)

27. Mannar of Death

1 DNaturai

2 Accident

3 Suicida

4 Homicida

Hampstead, Mil ake C 3000 Snyders bus ascade 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the caused, and manner as stated. Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number O.C.M.E. 29d. Dete signed (Month, Day, Year)

30. Name and andrass of person who completed causa of death (Item 23a) (Type, Print) estaner 20

271999

111 Penn Street, Baltimore, Maryland 21201

3e 31. Data tiled (Month, Day, Year)

32. Registrar's Signetura

State Registrar

DHMH 16 Rev 6/95

The law requires that the deeth

page 2 should be detached

this certificate has

Affer or Attanding

death.

To the Hospital within 24 hours a To the Funeral L Hospital

hours after death uneral Director:

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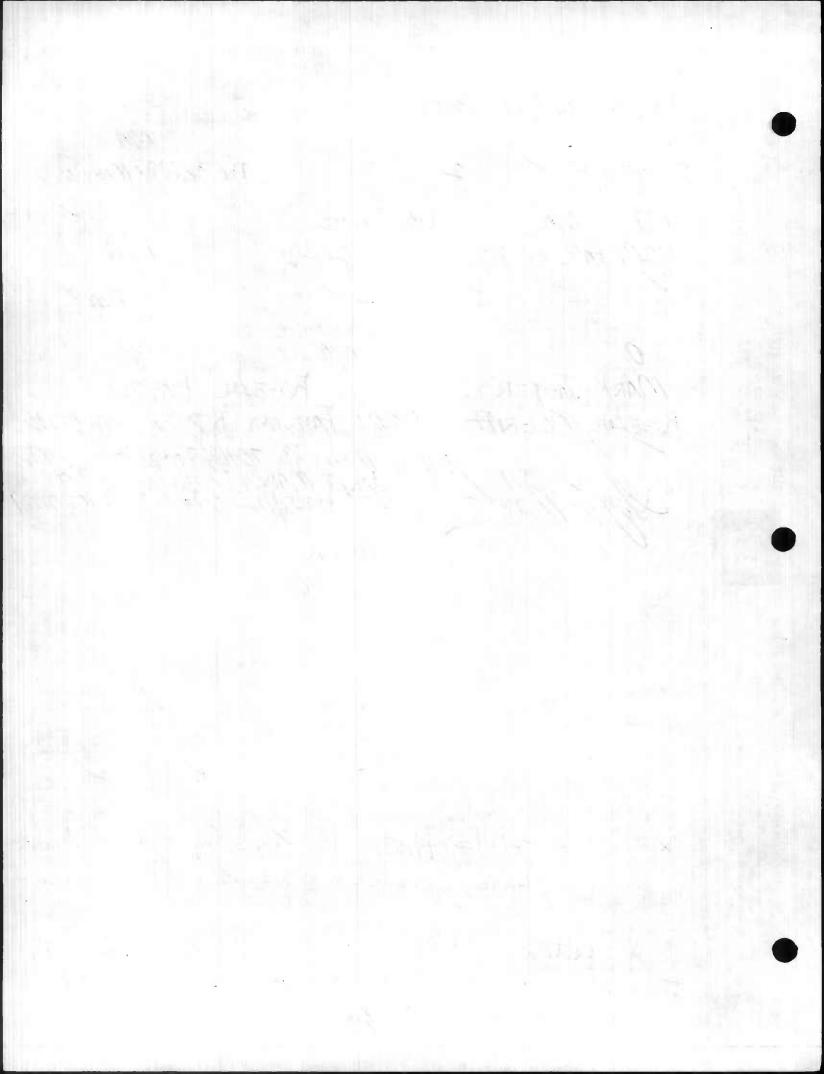
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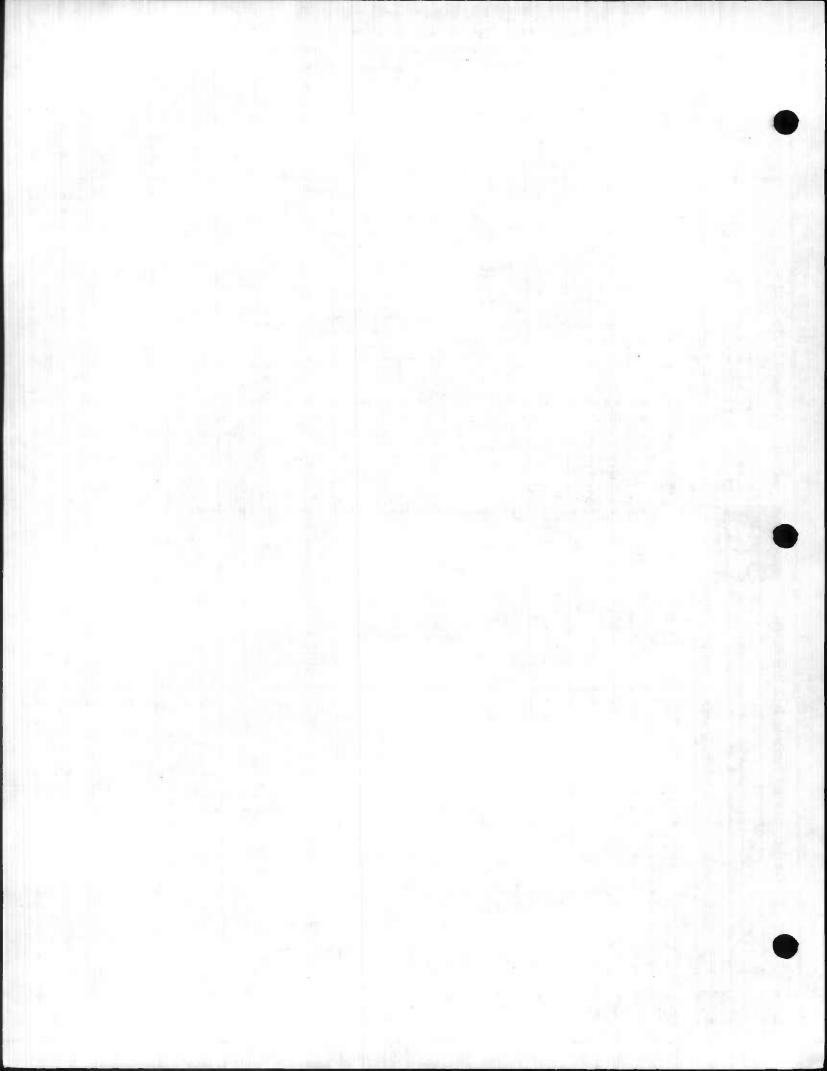
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Funeral Director	217-24-3 Usual Residence of IOa. Stete Maryland IOe. Street and No. 105 E. S 11. Marital Status 1 Never Mar 3 Widowed (Spe	B828 Decedent 10b. County Harford Harfor	Owt	10c. Gity	Yrs. y, Town or Lo	Months			irs. 8. Dete in. Man Jul	of Birth oth, Day, Y	1929	9. Birthplace Country) MOTUL	(State or Foreign
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2	21. Signature of F	uneral Service Licens	500		S	chum	inek	ss of Facility Functal Phail R	Home.	of Bel	e Air Air. M	Inc.	014
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Sit o Ctt n	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death)	Last	c		r as a conseq	a and a							
P	Part II. Other signi	licant conditions co	entributing to death	but not resu	ulting in the u	nderlying	cause giv	en in Part I.	23t	. Did toba	cco uee coi	ntribute to the	cause of death
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	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Place of I	njury - At ho etc. (Specif)	ome, farm, str	M set, fector		Yes 2 □ No	28f. Loca City	ation (Street or Town, S	et and Numb State)	per or Rural Roo	ıta Number,
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	29b. Signature and	title of certifier		OHES.		29	c. Licens	e number		29d	Dete signe	d (Month, Day,	Year)
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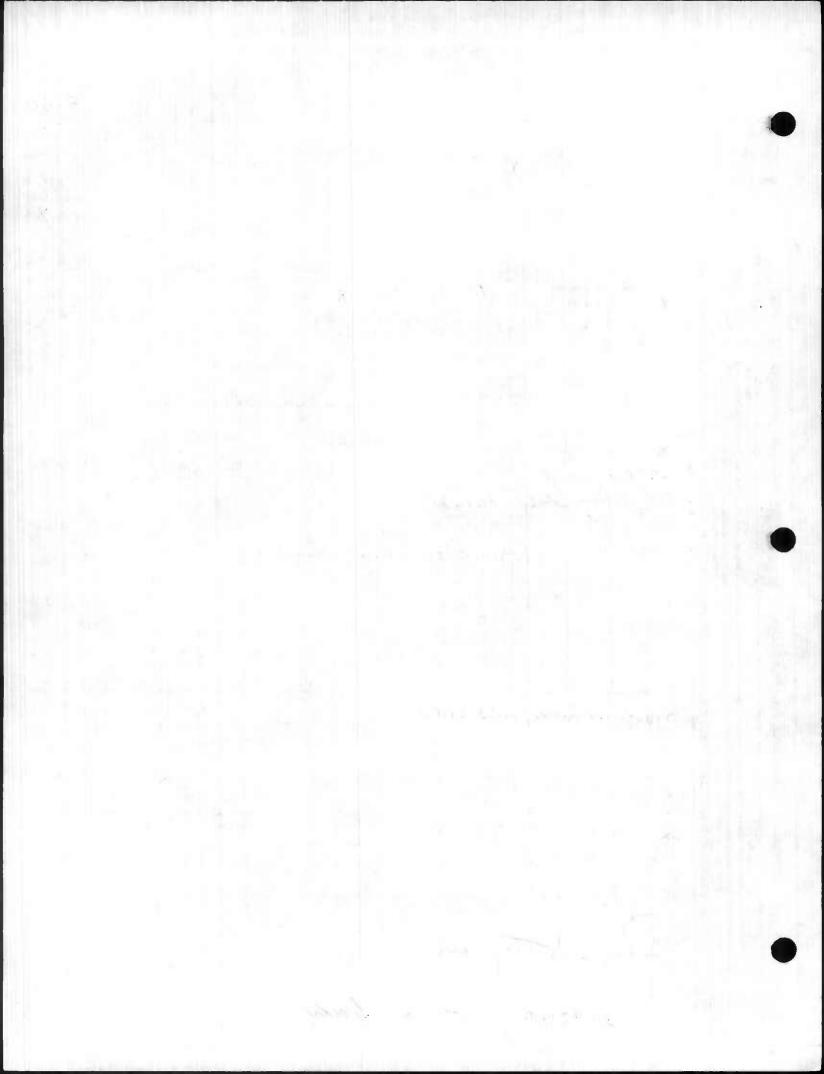
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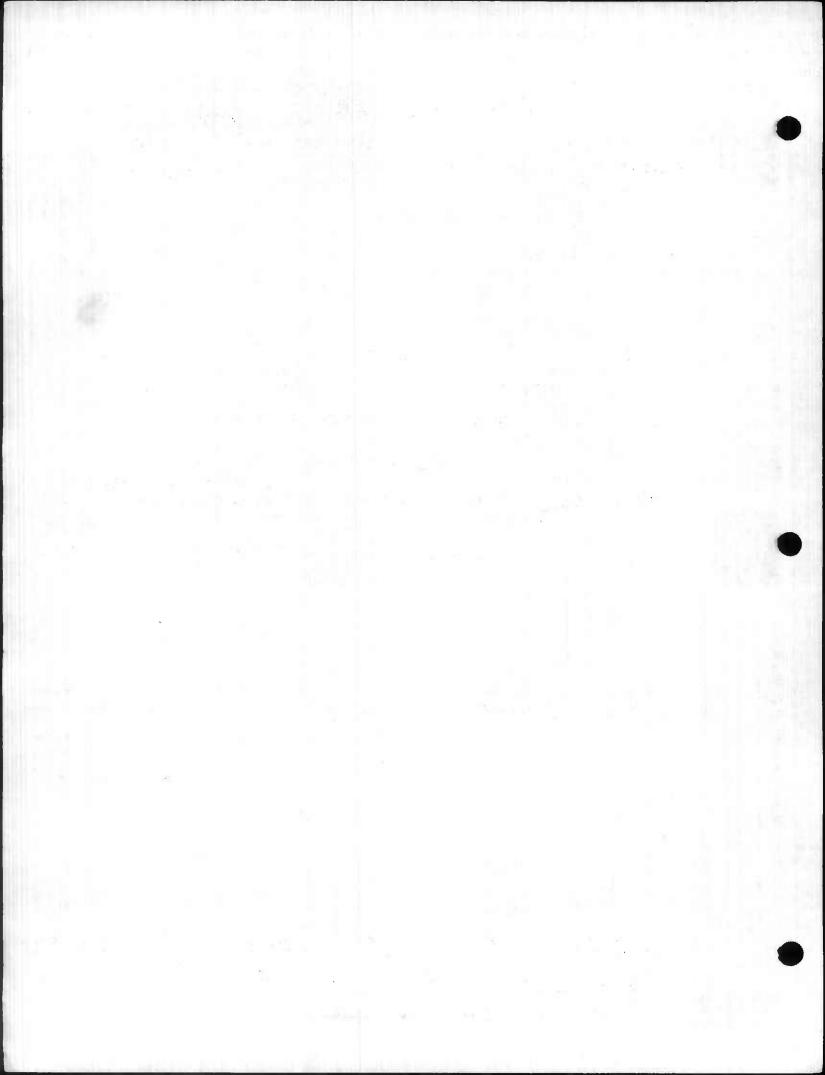
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	Examiner	4a Facility Name (If not institution, giv	e street and number)			4b. City, To	wn, or Loca	ation of Death	4c. County	of Death	
L			0214 Maxine Street				Ellicot				vard
	Funeral Director	216-03-7899	ex 7. Age (In y	rs. last birthday) 82 Yrs.	Months Days	If Under Hours	Min.	B. Date of Birt (Month, Day June 4	h, Year)		lace (State or Foreign try) Maryland
	pus M.	Usuel Residence of Decedent 10a. Stete 10b. County	10c.	City, Town or Lo	ocation					1	Od. Inside City Limits
	or 28a-f aho be notified		oward		T	llicott Ci	ty				1 Yes 2 No
	after death with the Marylan or items 23s or 28s-f show miner must be notified at / Funeral Director	10e. Street and Number 10214 Maxine Street			10f. Zip Code	210			10g. Citizen of V	U.S.	Α.
020	5 4 6	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No H Yes, Give Year or Detes:		Wes Decedent of I If Yes, specify Cub 1 Yes 2 No			ify Yes or No- ican, etc.)	Specify	k, White,	an Indian, etc. White
5-0	"natural", dical En	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occu	pation during mos	t of working	,	16b. Kind of Bu	siness/Inc	dustry
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any	d 2 should be the and Mente 7 is marked traumatic ar	19a. Informant's Name/Relationship (Type, Print)	19b. Meili	ng Address (Street	and Numb	er or Rural	Route Numbe	er, City or Town,	State, Zip	Code)
Z		Mr. Warren Klaschu	s Son	1	0214 Maxine	Street	Ellicott (City, Mary	land 21042		
Baltimore, Maryland 21215-0020	w _ = 0	20a. Method of Disposition 1	Removal from State	cemetery, cre-	osition (Name of matory or other pla IWn Memoria		ns 0	Date 7/26/99	20c. Location -		wn, Stete , Maryland
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	Physician /Medical	3. Pert1. Enter the dise e, or com shock, or heart feiler. List only		eeth. Do not en	ter the mode of dyi	ng, such as	cardiac or	respiretory er	rest,	1	Approximate Interval Between Onset and Death
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œ	The law ate hes page 2							101	res 20 No	10	Yes 2 No
Ita	ysicien: The lav is certificate has director, page 2 To Be Comp	25. Was case referred to medical axaminer?				26. Place	of Death	Check only o	ne)		
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	To the Hospital or Atlanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification;		ysician: To the best of my k ninar: On the basis of exami and menner stated.								
	within 2 To the comple	29b. Signeture end title of certifier			29c. Licen	se number			29d. Dete signe	(Month,	Day, Year)
	_/	1	17- M	2		D3	1473		July ?	4,1	999
	20	30. Name and address of person who are Toye, Patryce A. MD Do				cott City	, MD 21	043			11-11-12
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					epartment of F Sertificate of		R	eg. No.	9 63	010
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Examir	ner	4a. Facility Nama (If not Institution, git 16 FUSTING AV 5. Social Security Number 6.	Ε.	a (In yrs. last birtho		4b. City, Town, or Lo CATONSVII If Under 24 Hrs.	LE	BALT	y of Death IMORE	(State or English
Funeral Director			X 0 M 2□ F	77 Yrs	Months Days	Hours Min.	8. Data of Birth Alf Onth, Day, 4	1921	Country) GERMAN	(Stata or Foreig Y
Marylend If ahow	tor	MD 10b. County BALTIMO	RE	10c. City, Town o						nside City Limit
or 28	Director	10e. Street and Number			10f. Zip Coda		1		What Country?	
72 hours effer death with the Marylend naturel', or items 23a or 28a-f ahow steaminer must be motified at	by Funeral	6115 DEERBROOK 11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	ROAD 12. Was Dacedant Armed Forcas? Yas 2 N	No	21228 13. Was Dacedent of If Yas, specify Cub 1 Yas 2 No	lispanic Origin? (Sp an, Maxican, Puarto Specify:	ecify Yas or No- Rican, atc.)	Bla	ce - American Ir ick, Whita, atc.	idian,
c	Completed b	15. Decedent's Elementary/Secondary (0-12)	Year or Datas: ducetion ada complated) Collega (1-4or 5	16a. De	ecedant's Usuai Occup liva kind of work dona fa. DO NOT usa retire RE OWNER	pation during most of work d)	ing		Businass/Industr	у
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Men Men	To	FRANK K. KRISC				MARIA	1		TZEL	
7 10 10 10 10 10 10 10 10 10 10 10 10 10		19a. Informant's Name/Relationship MARY C. KRISCH			ailing Addrass (Street DEERBROO)				21 228	e)
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Departmen Important: any injury once.		21. Signatura of Funeral Sarvice Lice Role & Le	nsee Bret	~	22. Nama and Addre	, MT,	TZKE FUN UE, CATO			
hysician /Medical Examiner	ler	23e. Part1. Enter thà disease, or shock, or haart failure. List only immediata Cause (Final diseasa or condition rasulting in death)	a	Dua to (or as a cor	momac	ofs	lung	·		rval Between set and Death
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24 hours Funeral stely fille	edical	(Check only 2 Medical Example)	nysician: To the best of miner: On the basis of and mannar sta	axamination and/o	r invastigation, in my o	opinion, daath occur	red at tha tima, d	ata and place	, and dua to tha	causa(s)
within To the comple	M	29b. Signatura and titia of certifier	a Lu	rensny	29c. Licans	Sa number (18/8)		9d. Date sign	ed (Month, Day,	Year) 3, 199
ارسد		30. Nama and addrass of person who	complated causa of de		- District	rount Av			-1-	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month KOER BER 250 Am YNTHA BROOKE 25 4a. Fecliity Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death BILTIMORE If Under 24 Hrs. 8. Date of Birth Hours Min. July 20, 1954 Church Nursing Center If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Days 1 M 2 X 216-46-9964 45 Balto.MD Yrs. Usual Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5314 Tilbury Way 21212 Usa 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk Paint 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Louis Valentine Koerber Mary Lee Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis V. Koerber -father 5314 Tilbury Way Baltimore, MD 21212 20a. Method of Disposition 1 Disposition 3 □ Removal from State 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, Stete

Physician /Medicai

Physician

/Medical

Examiner

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Hem 27 is marked other than "naturel", or items 23s or 28s-f show key or other traumstic event, the Medical Examinal must be not filed at

Baltimore, Maryland 21215-0020

Examiner

and

physician

signed by the Medical Certification:

the Hospital or Attending Physician: The law requires that the death certificate be executed

certificate this

within 24 hours after deatl To the Funeral Director:

State

Registrar

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

4 □ Donation 5 □ Other (Specify)	Pa	rkwood	Cemete	ery	7/28/99	Balt	imore, MD
21. Signature of Funeral Service Licensee John D. Mittelsel	NIT.	Mitch 6500	end Address on ell-W:	Fecility Lede: Road	feld Fun Baltimo	eral H	Nome, Inc.
23a Fert 1. Enter the disease, or complication shock, or heart failure. List only one can	use on each line.	Do not enter the r	node ol dying, s	uch as car	diac or respiratory a		Approximata Interval Between Onset and Death
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Part II. Other significant conditions contribut	ing to death but not resultl	ng In the underlyin	g cause given li	Part I.		Yes 25 No	ontribute to the cause of death? 3 Probably 4 Unknown
·						an autopsy med?	24b. Were eutopsy findings aveilable prior to completion of cause of death?
					101	res 2/2/No	1 ☐ Yes 2 ☑ No
25. Was case referred to medical examiner?			26	. Place of I	Death (Check only o	ne)	
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1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	a. Dete of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury et Work? 1 ☐ Yes	2 □ No	28d. Describe i	now Injury occur	red
3 Suicide 6 Could not be determined 28	e. Place of Injury - At home building, etc. (Specify)	e, ferm, street, lec	tory, office		28f. Location (5 City or Tox		ber or Rural Route Number,
29e. Certifier (Check only one) Certifying Physician 2 Medicat Examiner: O	: To the best of my knowle on the besis of exemination and manner steted.	edge, deeth occurr a and/or investigat	ed at the time, dion, in my opinio	ate and ple n, deeth o	ece, end due to the occurred at the time,	cause(s) and mo dete and piece,	enner as stated. and due to the cause(s)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARCH

32. Registrar's Signature

CLARENCE SARKEBEE - ABVO

JUL 27 1999

31. Date liled (Month, Day, Year)

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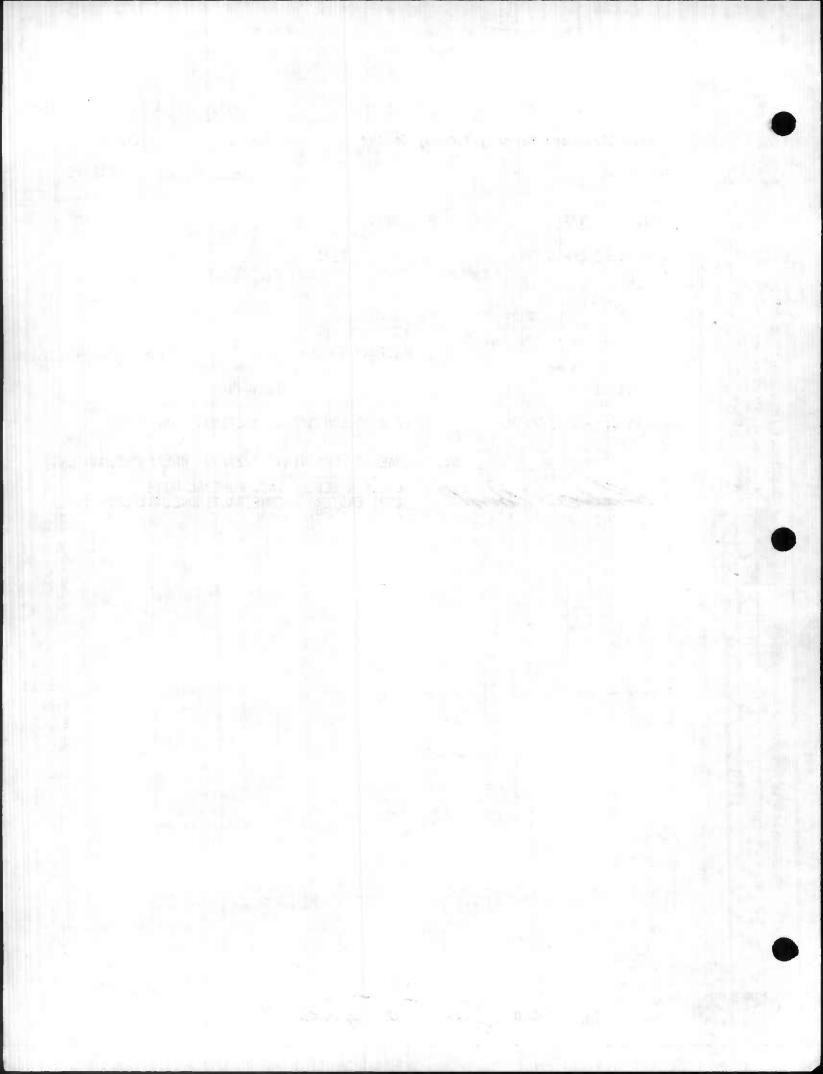
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:45PM 25 1999 Eva Krawczyk July /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare Perring Parkway Center HILLENDALE BALTIMORE If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 1□M 2√2 F 93 UKRAINE Director 212-32-1631 March 14,1906 Usual Residence of Decedent the Manyland 10a State 10b. County 10c. City. Town or Location ahow 10d. Inside City Limits than "natural", or items 23s or 28s-f above the Medical Examiner must be notified as 1X Was 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3104 ROSEKEMP AVENUE 21214 UKRAINE Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Waa Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: py 3 M Widowed 4 □ Divorced Yeer or Dates: WHITE Completed 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER COMFORT SPRINGS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Peges 1 and 2 should be fill thent of Health and Mental Hant: If Itam 27 is marked oth Jury or other traumetic avan Be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM C. BUDKO/FRIEND 5417 BIDDISON AVENUE, BALTIMORE, MD. 21206 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) MICHAEL'S UKRAINIAN 17/28/99 BALTIMORE MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ementia /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examiner heart Failure The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. Physician/Medicai Due to (or as a consequence of) S 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Records, py 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No certificate 1 Yes 2 No Division of Vital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 DNatural 5 Pending s after death.

I Director: Af 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) within 2. To the 943 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 053642 Sician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) thern Park Way Baltimore 21214 MINGX 2HOU 300 Dr 31. Date filed (Month, Day, Year) State

BAB

DHMH 16 Rev 6/95

Registrar



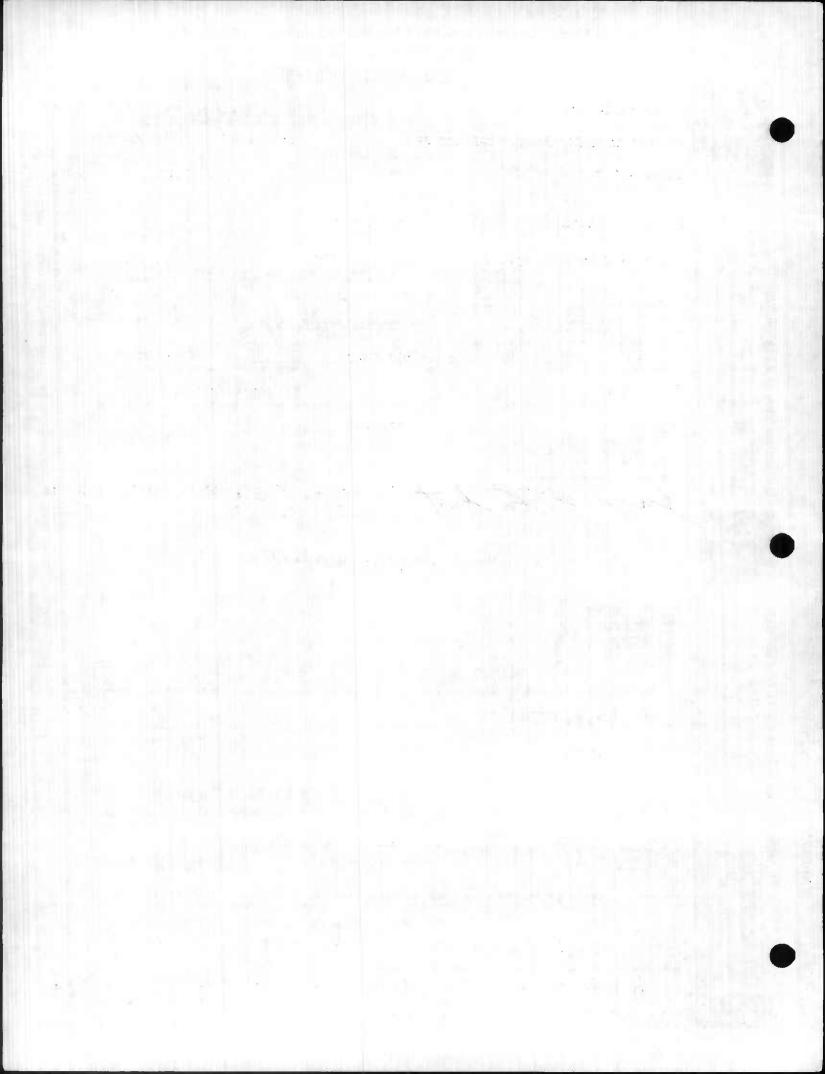
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State of Maryland / Department of Health and Mental Hygiene Q

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060-05-3517

ISABEILE M. LOWRY

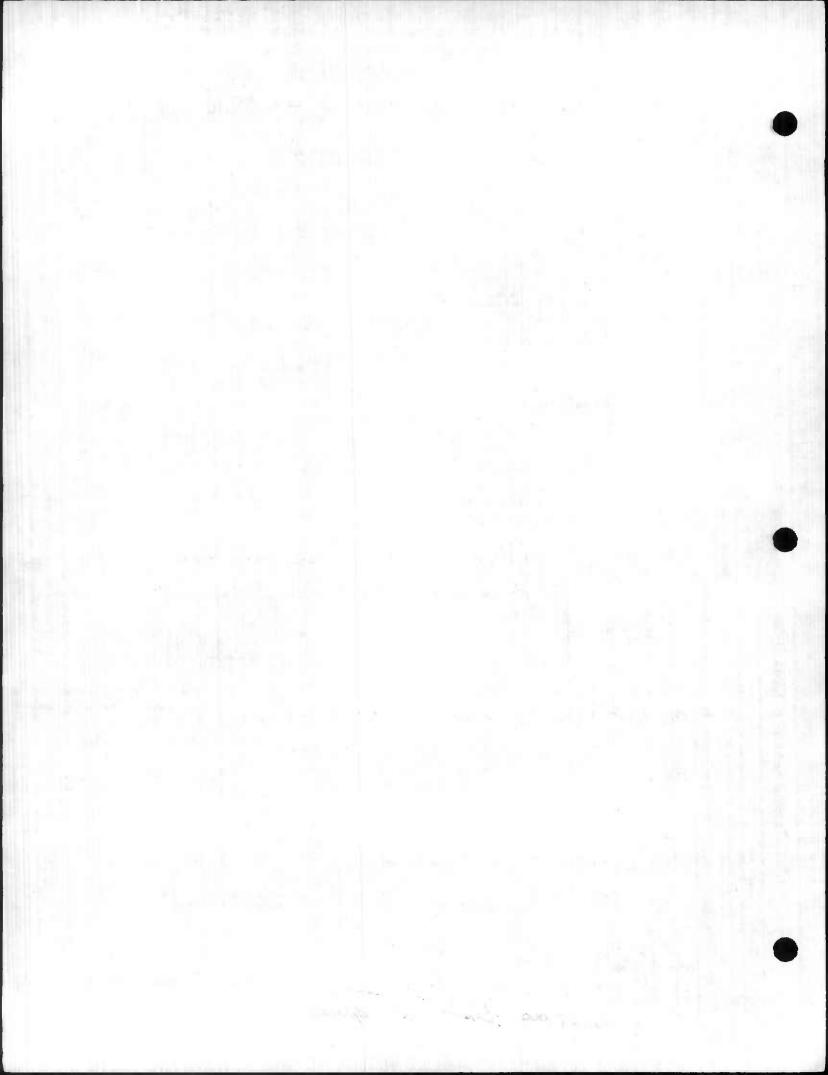


Please Type or Print in Biack Indelibie ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		,	Certificate of	of Death	Reg. No.	1 23020
Physician	1. Decedent's Name (First, Middle, La		1		e of Death	Year 3. Time of Death
/Medical		ENDELL	LEHNER			999 1:250
Examiner	4a Facility Name (If not institution, given St. Elizabeth Nu.	rsing Home		4b. City, Town, or Location of Baltimore		
Funeral Director	204-22-6071	Sex 7. Age (In yrs. 12 M 2□ F 69	last birthday) If Under 1 Ye Yrs. Months De	par If Under 24 Hrs. 8. Determines Min. Sep.	of Birth ntri, Day Year) 1929	9. Birthplace (Stete or Foreign Country) Pennsylvania
P .	Usual Residence of Decedent 10a. Stale 10b. County	10c. Git	y, Town or Location			10d, Inside City Limits
vith the Merylen t or 28e-f show be notified at Director	7		ltimore			1 M Yes 2 No
deeth with the Maryland ms 23a or 28s-f show Entast be notified at here! Director	10e. Street and Number 3320 Benson Aver	nue	10f. Zip Cod	L227	U.S.A.	
tio or items 23a miner meet	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Wes Decedent	of Hispanic Origin? (Specify Yearban, Mexican, Puerto Rican, e	s or No-	- American Indian, k, White, etc.
b # 50 0	3 ☐ Widowed 4 ☐ Divorced	1 TYPES 2 No	rea 1 Yes 201		Specify.	White
1 21215-002 sed within 72 hours yogiene. we then "netural", if the Medical Est	15. Decedent's Ed (Specify only highest gri		16a. Decedent's Usuel Oc	cupation	16b. Kind of Bu	siness/industry
2121 2121 d within piere. r than '	Elementary/Secondary (0-12)	College (1-4or 5+)		ne during most of working tired)	D	· Chann
nd 2.	17. Father's Name (First, Middle, Last	2	Salesman	18. Mother's Name (First,	-	ment Store
Maryland de should be file the and Mentel Hyp. The marked other treumatic event				Frances Hele		,
re, Mary 1 and 2 sho Heelth and I em 27 le me other treums	19a. Informant's Neme/Reletionship (Ginger L. Nalle		19b. Meiling Address (Str. 982 Circle	eet and Number or Rural Route Drive, Arbutus	Number, City or Town, Maryland	State, Zip Code) 21227
2 222	20a. Method of Disposition	Removel from State	Mace of Disposition (Name of emetery, cremetory or other w Cathedral C	plece)		city or Town, State re, Maryland
Baltimo	4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		22. Name and Ad			
Dem Depa Impo	Handa Li	remmer	1630 Edm	ondson Avenue,		
-	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	n. Do not enter the mode of	dying, such es cardiec or respir	etory errest,	Approximate Interval Between Onset end Death
Physician /Medical	Immediate Cause (Finel	D.	\circ			
Examiner	disease or condition resulting in death)	. BILATER	AL BRON	chopreum	ONIA	Iweek
i i		Due to (o	r as a consequence of):	- P.0		
58760, cete be executed physician and sine burle-transit addical Examiner	Sequentially list conditions	b. RECURRE	r as a consequence of):	ATION PNEC	MONITIS	1 week
essential Experience	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
(68760, rifficete be an apphysician see the burde	that initiated events resulting in death) Last	0.	r as a consequence of):			
E 00 5	C	d				
	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the underlying cause	given in Part I 23	b. Did tobacco use con	stribute to the cause of death?
P.O. et the di the di the di the di the di the di the eteched	no 141-10 Pa		/			3 Probably 4 Unknown
S, F er the bede bede	MUITIPLE PREV	ious Cerer	BROUASCULAR	- ACCIDENTS		
COr v requ been should	Aphasia . Dyspl	LAGIA NON-1	usulin depe	NOENT	a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
f Vital Reysten: The levis certificate has director, page 2	Dialotos Ma		TIC STENO		1□Yes 2₽No	1 Yes 2 No
	25. Was case referred to medical examiner?	allos. Hox	- 112 OTENA	26. Place of Deeth (Chec	k only one)	
- 5 0 D	1 Yes 2 14 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	Other: 4 Nursing Home 5	☐ Residence 6 ☐Othe	or (Specify)
on of ding Phy h. After thi funeral tion: T	27. Mannis of Death 1 Partural 5 Pending	28a. Date of Injury (Month, Day Year)		Nork?	scribe how Injury occurr	ed
South tond	2 Accident investigation 3 Suicide 6 Could not b	9		I ☐ Yes 2 ☐ No	ation (Street and Mumb	os os Burol Bouto Number
DIVISION C tal or Attending P in effector: Affect ed in by the funeral Certification:	4 Homicide determined	building, etc. (Specif)	ome, farm, street, factory, offi ()	Ce 201. LOC Ch)	or Town, State)	er or Rural Route Number,
DIVISION To the Hospital or Attending within 24 hours effer death. To the Funerel Director: Affer completely filled in by the fune Medical Certification	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, death occurred et the tion and/or investigation, in m	e time, date and plece, end due by opinion, death occurred et the	to the cause(s) and ma e time, date and place, a	nner as stated. ind due to the cause(s)
to of the company of	29b. Signeture and title of certifier	ATTENDING	Mysician]	ense number	29d. Date signed	(Month, Day, Year)
117/	30. Name and address of person who				100,7	. //
10.7	DR. N. M. MA	CHIRAN 720	-C MAIDEN	Choice LA	CATONSU	ille, MU 22/2
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture			
Registrar	JUL 27	1999 Dunia	p. spa	us		

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 2:40A1 1999 Richard W. Loek JULY /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street end number) **Examiner** CATON MANOR GENESIS ELDER CARE BALTIMORE If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 1 M 2 □ F Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months 398-44-2500 **Director** Feb. 4, 1916 Wisconsin Usuel Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d, Inside City Limits tem 27 is marked other than "neturet", or items 23s or 28s-f show other treumstic event, the Wed call Examiner must be notified at 1 ☐ Yes 2 No Director MD Clarksville Howard 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number 6022 Trotter Road 21029 U.S.A Funeral Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 10 altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White py 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Never Worked Never Worked permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg important: if item 27 is marked other any injury or other treumestables. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Ellen Schigner Fred Loek 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Pnint) Marie Brown Cousin 6022 Trotter Rd, Clarksville MD 21029 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Balt./Wash. Crematory 7/25/99 Laurel, MD 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licensee Witzke Funeral Homes, Inc. Relut-23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List entry one cause on each line. Columbia, MD 21045 **Physician** (week Immediete Ceuse (Finel diseese or condition resulting in death) /Medical Examiner 1 Hours (eleens Examiner 12001 certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other atgnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yaa 2 No 3 Probably 4 Unknown pertensum Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? DON: 1 TYGE 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Deeth Check only one Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of Injury (Month, Dey Year) funerel 27. Manner of Deeth

1 A Natural

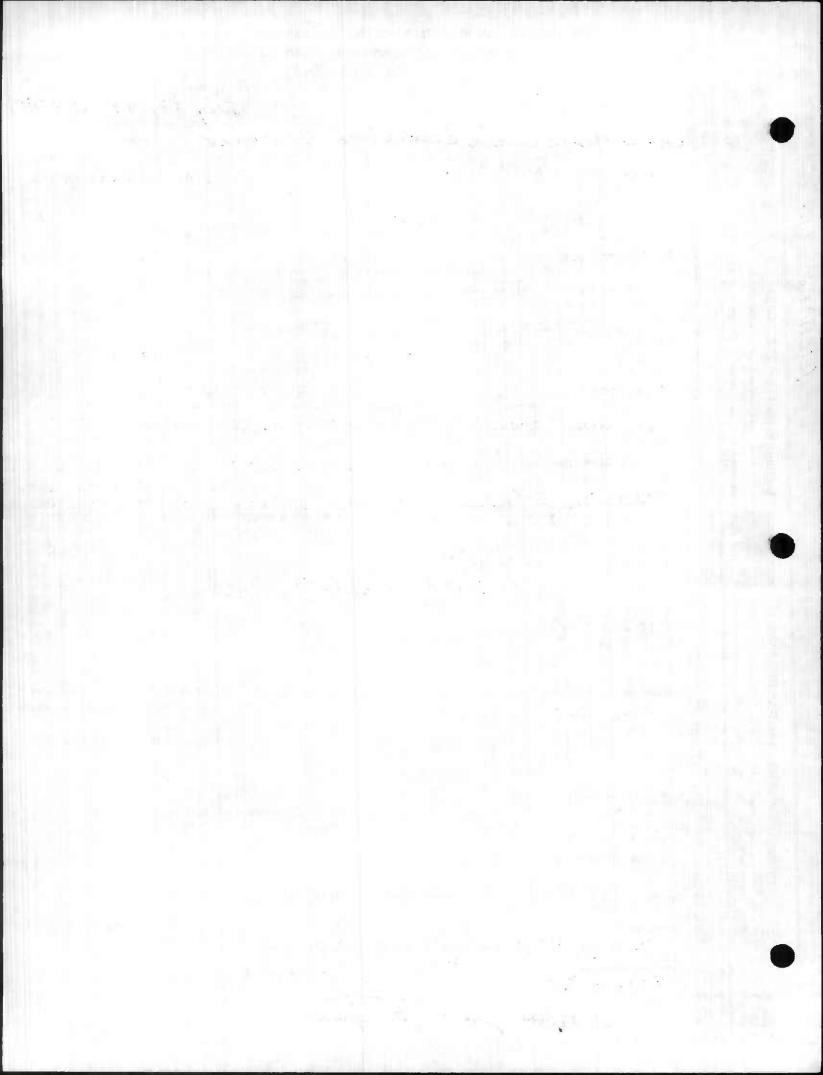
2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation s efter deeth.

I Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral I 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and mennar as steted. completely 2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner stated. (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier Altending Doctor (Wymac M) 7-24-1989 D 2165-4 30. Neme and address of parson who completed cause of deeth (Item 23e) (Type, Print) 8109 RITCHIR HWY, PASADENA, MD 21122 V.CYRIAC.M.D

Registrar

31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

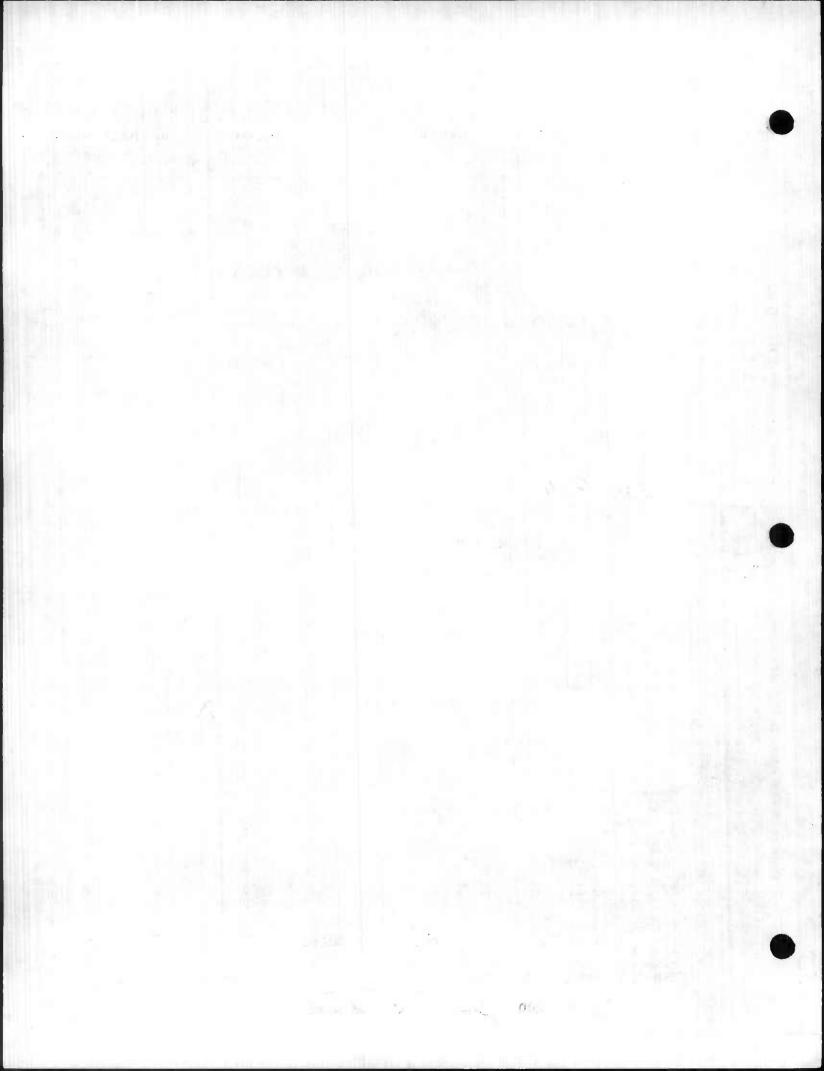


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ()

23622 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** FRANCES G. LEVERING 21. JULY 1999 11:55 AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore | Number 1 Year | Number 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 08-08-1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 MX 20 F 79 262-26-7903 Yrs. Director WASH., D.C. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. Stete 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Weddell Examiner must be notified at MD. BALTIMORE TOWSON 1 Yes XX No Director 10a. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 1055 WEST JOPPA ROAD 21204 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Merital Stetus hours after 1 Never Merried Merried 1 ☐ Yes XX No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: WHITE Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 t Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natu any injury or other traumats and any 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) YEARS HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) 8 WALTER GULLION MARTHA SANFORD 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK A.LEVERING, IV (SON) 7909 GREENSPRING AVE., BALTO., MD., 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial XX Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 7-22 BALTO., MD., 21202 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY W. JENKINS AND SONS COMPANY 21. Signature of Funeral Service Licensee 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** /Medical LUNG CANCER Immediate Cause (Finel MONTHS disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): P.O. Box 68760, 2 Physician/Medical Due to (or es a consequence of) the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Yea 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE signed t Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? certificate has 2 200 2K) No 25. Was case reterred to medical axaminer?

1 Yes 2 No Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 10 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred or Attending Patter death. After 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plecs of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 Homicide Hospital 124 hours a Funerel D 29e. Certifier 12 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 30263 30. Nema and address ot person who completed cause ot death (Item 23a) (Type, Print) FRANCIS KHOO, M.D., 7601 OSLER DR. . TOWSON, MARYLAND 32. Registrar's Signature Registrar



egibie.

IVI	L)					
	99-4347-510	Please Type or Print in Black Indelible in	k. Assure A	II Copies A	re L	egibie.
	JOHN LANHAM IV AMEND ITEMS: #	State of Maryland / Department of Waryland / Department	Health and I	Mental Hygi	ene g. No.	99
	Physician /Medical John Will:	iam Lanham IV		2. Data of Death Month JULY	Day 23.	Year 1999
		ot institution, giva street and number)	4b. City, Town, or I	ocation of Death	4c. C	ounty of Death

7. Aga (In yrs. last birthday)

10c. City, Town or Location

Baltimore

20

Funeral

Director

than "natural", or itema 23a or 28a-f show the Wedical Examiner must be notified at

Director

Funeral

p

Completed

8

the Maryland

WITH

death

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. Int: If Item 27 is marked other than Irry or other treumstic svent, the M

Department o important: If any injury or

Physician /Medical

Examiner

burial-transit

the

88 for use

signed by the a d be detached f

page 2

funeral director,

filled in by

certificate

this

After

24 hours after death.

Funeral Director: A

within 2 2

or Attending Physician:

Hospital

physician

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

Examiner

Physician/Medical

Completed by

8

Medical Certification: To

Baltimore, Maryland 21215-0020

419 MILLINGTON AVE 5. Social Security Number

220-15-4078 Usual Rasidance of Decedant 10a. Stala 10b. County

Maryland n/a 10e. Streel and Number

3215 Magnolia Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No 1 Never Married 2 ☐ Married

Yaar or Datas

College (1-4or 5+)

10 M 20 F

6. Sex

21227 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.)

16a. Decedani's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)

10f. Zip Code

If Under 1 Yea

Months

Days

1 ☐ Yas 2 No Specify:

BALT IMORE
If Under 24 Hrs.

Min.

Hours

18. Mothar's Nama (First, Middle, Maiden Surname)

July 24,

14. Race - American Indian, Black, White, atc. Specify: White

16b. Kind of Business/Industry

education

10g, Citizen of What Country?

United States

n/a

1979 Maryland

23623

3. Time of Death

7:00P.M.

10d, Inside City Limits

1 No Yes 2 No

Birthplaca (State or Foreign Country)

11 17. Falher's Nama (First, Middla, Last)

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

John William Lanham, Jr.

Deborah Ann Lanham

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) John W. Lanham, Jr. - father

15. Decedent's Education (Specify only highest grade completed)

20b. Place of Disposition (Name of cemetery, crematory or other place)

student

3215 Magnolia Avenue, Baltimore, Maryland 21227 20c. Location - City or Town, State Date

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Loudon Park Cemetery 22. Nama and Addrass of Facility Loudon Park Funeral Home

7/26/99 Baltimore, Maryland

23a. Part1. Entar tha diseesa, or complishock, or heart feilure. List or ly or pli atit as that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one of use on each line.

3620 Wilkens Avenue Baltimore, Maryland 21229 Approximate Interval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)

20a. Method of Disposition

NARCOTIC INTOXICATION

Due to (or as a consequance of):

Dua to (or as a consequence of):

Due to (or as a consequenca of)

Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disasse or injury that initialed events rasulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Onknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No 26. Place of Death (Check only one)

Other: 4 Nursing Homa 5 Residence 6 MOther (Specify) YARD

1 Stes 2 □ No

25. Was case referred to medical 1X Yes 2□ No 27. Manner of Death

5 Pending invastigation 6) Could not be detarmined

28a. Data of Injury (Month, Day Year) UNKNOWN 28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify)
FOUND: REAR YARD OF PRIVATE DWELLING

Hospital:

28b. Time of UNKNOWN

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yas 2 ☑ No

28d. Dascribe how injury occurred SUBJECT INGESTED NARCOTIC

 Localion (Street and Number or Rural Route Number, City or Town, Stata) 419 MILLINGTON AVE. CITY, MARYLAND BALTIMORE

29a, Certified (Check only one)

1 Natural

3 ☐ Suicide

2 Accidant

4 Homicida

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

**Contifying Physician: To the basis of axaminetion and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of pertifier

O.C.M.E.

JULY 24,1999

30. Nama and address of pa on who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

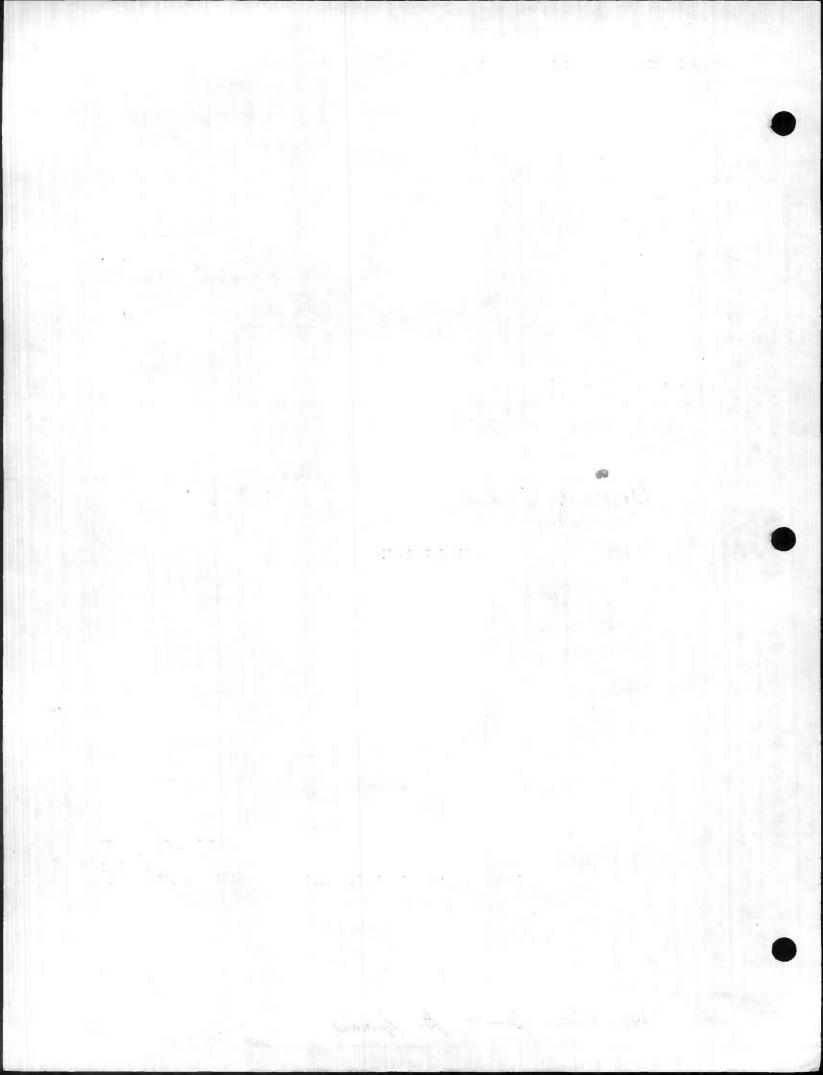
State Registrar

JUL

31. Date filed (Month, Day, Year)

32. Registrar's Signatura

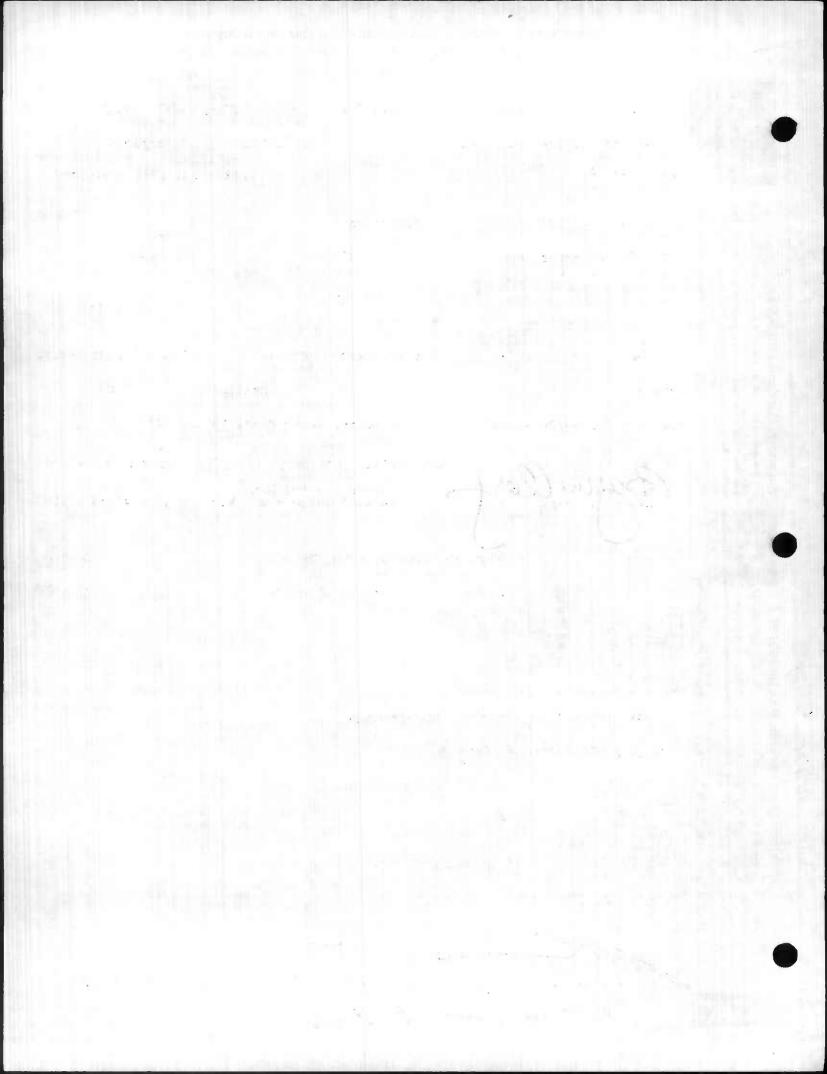
DHMH 16 Ray 6/95



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State of Maryland / Department of Health and Mental Hygiene 9 9 2 3 6 2 4

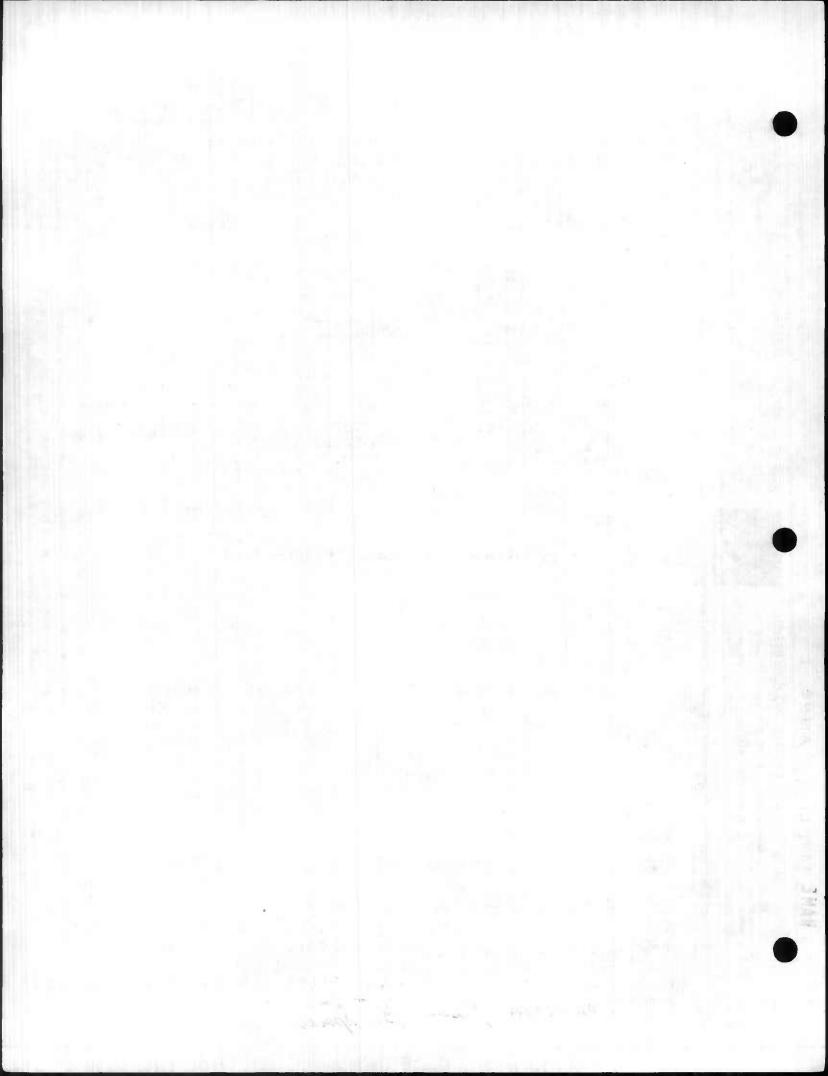
			(Certificate o	f Death		Reg. No.		
	1. Decedant's Nama (First, Middla,	Last)				2. Deta of D	Death Dey	Year	3. Tims of Death
nysician Medical	Emory	Edward	Mi1	ler, Sr.		JULV	25	1999	6:09 PM
aminer	4a Fscility Nama (If not institution,	give street and number)			4b. City, Town, or	Location of De	ath 4c. County	of Death	
	Fallston Gene	ral Hospital			Fallst	on	Har	ford	
eral		S. Sex 7. Age (II	yrs. last birth	nday) If Undar 1 Ya	ar If Under 24 Hrs	s. 8. Date of E			ce (State or Foreign
ctor	216-22-4024	¹\\ M 2□F 71	Y	rs. Months Day	rs Hours Min	April	23, 1928		yland
	Usual Residence of Decedent								
Director	10a. Stele 10b. County	10	c. City, Town	or Location				10d	d. Inside City Limits
to	Maryland Harfo	rd	Fo	rest Hill					1 Yes 2 No
Director	10e. Street and Number			10f. Zip Code	1		10g. Citizen of	What Country	y?
	1239 Sharon Acr	es Road		210	50		US	A	
Funeral	11, Maritai Status	12. Wes Decedent Eva	r in U,S.	13. Was Decedent o	Hispanic Origin? (Specify Yas or I		e - American	
Fur	1 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 ☑ No			uban, Mexican, Pue	no Hican, atc.)		ck, White, etc	c.
by	3 ₩ Widowed 4 Divorced	If Yes, Give A Year or Dates:		1 ☐ Yes 2 ☐ N	lo Specify:		Specify	Whit	e e
8	15. Decedent's	Education	16e. [Decedent's Usual Occ	cupation		16b. Kind of B		
Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)		(Give kind of work dor life. DO NOT use ret	na during most of wo ired)	orking			
E	08	n/a	Co	nstructio	n Foreman		Genera	1 Cont	racting
BeC	17. Fathar's Nama (First, Middle, Li				1		lle, Malden Sumar		
To Be C	Edward		Miller	•	D	ellie		Hare	
F	19a. Informant's Name/Ralationshi	o (Type, Print)		Mailing Address (Stre			nber, City or Town		Code)
	Mary Ann Bosley/			239 Sharon					21050
	20a. Method of Disposition		20b. Place of I	Disposition (Nama of		Date Date	20c. Location		
6	1 Burial 2 □ Cramation 3		cemetery	, crematory or other p	olace)				
5	4 Donation 5 Other (Spe		Stable	rsville Co		7/28/9	9 Parkto	on, Ma	ryland
any injury	21. Siz a Lof Funerai Service LI	1 Corel		22. Name and Add	uneral Ho	me			
a O	Bryan W. Cla	ry	,		donia Roa		nium, Ma	ryland	21093
	23a. Part1. Inter the di aasa, or c shock, or heart fair re. List or	omplications that caused the	death. Do no	ot enter the mode of o	tying, such as cardie	ec or respiratory	errest.	A	Approximete nterval Between
cian	STOCK, Private Land	n, one soul on cash						C	Onset and Death
dical	Immediate Ceuse (Final disease or condition	acuta		adial infa	ction				5min
iner	resulting in deeth)	a. QCO/C	to (or as a co	rdial infar	2710.				9 (1111)
je l				emic hear		0			10 years
edical Examiner	Sequentially list conditions			ernic rieur onsequence of):	1 413643				1000
EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury								
20 20	that initiated avents	C.	to (or as a co	onsequence of):					-
8	rasulting In death) Last	500	7.0 (0. 20 2 00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
N. Car		d							
Physician/Med	Dad II Other stantillands and and	a anniality state of the state	ad an activity	the underlying	alon in Dec. 1	905 0	ld tobecon	matelianate de 1	the name of death of
d be detached for use	Part II. Other significant condition	s contributing to death but n	or resuming in	una undanying cause	gwan m Mart I.		1		the cause of death?
P P	metastatic	ung cancer.	hune	rtension.		1)	Yee 2 No	3 Probe	ibty 4 🗌 Unknow
dby	metastatic	7	11	,		240 141	as an eutopsy	24b Wer	e autopsy findings
Completed	Chronic obstr	uctive luna	disea	250		pe pe	erformed?	avail	lable prior to pletion of cause
N D		J						of de	eath?
Pege 2	Smoking					40	□Yes 2×No	10	Yes 2 No
Be G	25. Was case referred to medical examiner?					eath (Check onl	ly one)		
al director, pege	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Out	patient 3 DOA	Other: 4 Nursing	Home 5□Re	esidence 6 🗆 Oti	ner (Specify)	
funeral di	27. Menner of Deeth	28a. Date of Injury (Month, Day Ye	28b. Ti	ime of 28c. In	njury at Vork?	28d. Describ	e how injury occu	rred	
the funer cation	1 Neturel 5 ☐ Pending 2 ☐ Accident investige		, , , , ,		☐ Yes 2☐ No				
If the	3 Suicida 6 Could no	ad 200. Place of Injury	- At home, fan	m, street, factory, offic	се		(Straet and Num	ber or Rural i	Route Number,
d in	4 Homicide	building, etc. (Бреспу)			City of I	Town, State)		
	29e. Certifier 152 Certifying	Physician: To the best of m	v knowledge.	deeth occurred at the	time, date and place	ce, and due to the	he cause(s) and m	anner as sta	ted.
completely filled in by the funera	(Check only 2 Medical E:	caminer: On the basis of examiner stated	amination and	/or invastigation, in m	y opinion, death occ	curred at the tim	ne, date and plece,	end due to t	the cause(s)
Mec Mec	29b. Signature and title of certifier	with mailtier stated	*	29c, Lice	ensa number		29d. Data signe	ed (Month, D	lay, Year)
8 -	and the or certified						-		1000
	1110		O	D	57517		July	25, 1	777
	30. Name and address of person w			**	2				
	David C. Rubi	n mD 104	Plumt	tree Rd	Bel A	ir m	aryland	2101	15
State	31. Date filed (Month, Day, Year)	32. Registrer's							



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State of Maryland / Department of Health and Mental Hygiene | Q | Q

					Ce	rtificate c	of Death		Reg. No.	,	
	sician edical	Decedent's Nama (First, Middla, A	(asi) nna Eli	zabeth	Macl	Leod		2. Data Mon Jul	of Death	y Year	3. Time of Death 23 1 30
L.	niner	48 Facility Nama (If not institution, ST. AGINES HOS			ron.		BALT	m, or Location of	Death 4c.	. County of Death	'Δ
Funer Direct	_	061-10-7370	6. Sex 1 □ M 2√□ F	7. Age (In yrs. 9 (Months Da	ar If Under 2 lys Hours	Min. (Mon	of Birth th, Day, Year) Y 31, 1		placa (Stata or Foreign htty) W York
death with the Manyland ms 23e or 28e-f ahow	tor	Usual Residence of Decedent 10a. Stata 10b. County Maryland Bal	timore	10c. Ci	ly, Town or L		atonsvi	ille			10d. Insida City Limits 1 ☐ Yas 2 ☐ No
ith with the Maryla 23a or 28a-f ahor ant be notified at	al Director	10e. Street and Number 6348 Frederi				10f. Zip Cod			10g. Citi	izan of What Coul	
be filed within 72 hours after deat tal Hygiene. d other than "natural", or ftems 2 avent, the Medical Experies mu	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	Armed Fo	2₽No va X		Was Decedent of Yas, specify C		in? (Specify Yas Puarto Rican, a		14. Race - Amark Black, Whita, Specify:	
n 72 hou netura	pet	15. Decedent' (Specify only highast	s Education		16a. Dece (Give	dent's Usual Oc a kind of work do DO NOT use re	cupation ona during most of	of working	16b. Ki	ind of Businass/In	
Dan H	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	_	comer S			T	elephon	e Compan
Aental Hygrked other	To Be C	17. Fether's Nama (First, Middla, L Thomas	*	S			18. Mother	's Nama (First, M Mar		Sumame)	
le mer	-	19a. Informant's Name/Relationsh								or Town, State, Zip	
Important: If item 27 is marked other than "I any injury or other traumatic avent, me Tex		Mary Beth Cel 20a. Method of Disposition 1 Burial 2 A Cremation 4 Donation 5 Other (Sp	3 □Removal from	20b. F	cematary, cre	Governosition (Nama of other of other of other other)	piace)	7/26/		nie, MD ocalion-City or To altimor	
hysicia /Medica xamine	ın al	Dawn F 23a. Part1. Enter tha disease, or a shock, or heart failura. List of the shock of the sh	complications that only one cause on a	RACE	h. Do not en	299 Fred lar the mode of LAL Harduence of):	derick dying, such as c	Road	Balt itory arrast,	yland,	MD 21228 Approximate Inlarval Batween Onset and Death WEEK
attending physician and for use as the burial-transit	Medical	Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Dua to (d	of as a conse	quence of):					
ed by the att	Physician/	Part II. Other significant condition	s contributing to d	eath but not ras	ulting in the	underlying cause	given in Part I.	231		14	o the cause of death?
requires 1	Completed by	144						248	. Was an autop performed?	av cc	fere autopsy findings vailable prior to impletion of cause death?
The law pate has to page 2 s	Com								1□ Yes 2	XNo 1	□ Yes 2 No
Physician: The this cartificata ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	EB/Outnatie	nt 3 DOA	Other	of Death (Check		6 □Othar (Speci	(v)
or Attending ifter death. Director: After in by the funa	Certification: T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	28a. Data (Mon	of Injury th, Day Year)	28b. Tima o Injury	of 28c. I	njury at Work? 1 ∐ Yes 2 □ N	28d. Des	scribe how Injui	ry occurred	
To the Hospital within 24 hours a To the Funeral C completely filled	edical C	29a. Certifier (Check only one) Certifying Medical E	Physician: To the xaminer: On the b	best of my kno asis of axamina ner stated.	wledge, deat	th occurred at the	a time, data and ny opinion, daath	place, end due n occurred at the	to the cause(s) tima, data and) and manner as a d place, and due t	stated. o tha cause(s)
To the vithin To the comple	ž	29b. Signeture and title of certifier					ense number		29d. Da	la signed (Month,	Day, Year)
		417	TEDICAL				2590		34	LY 26	1999
S Regi:	State strar	30. Name and eddrass of person w RICHARD OFFEI 31. Data filed (Month, Day Year)	ADDO M		DO CA		AVENUE	E, BALT	IMORE	E MARYLI	AND, 21229

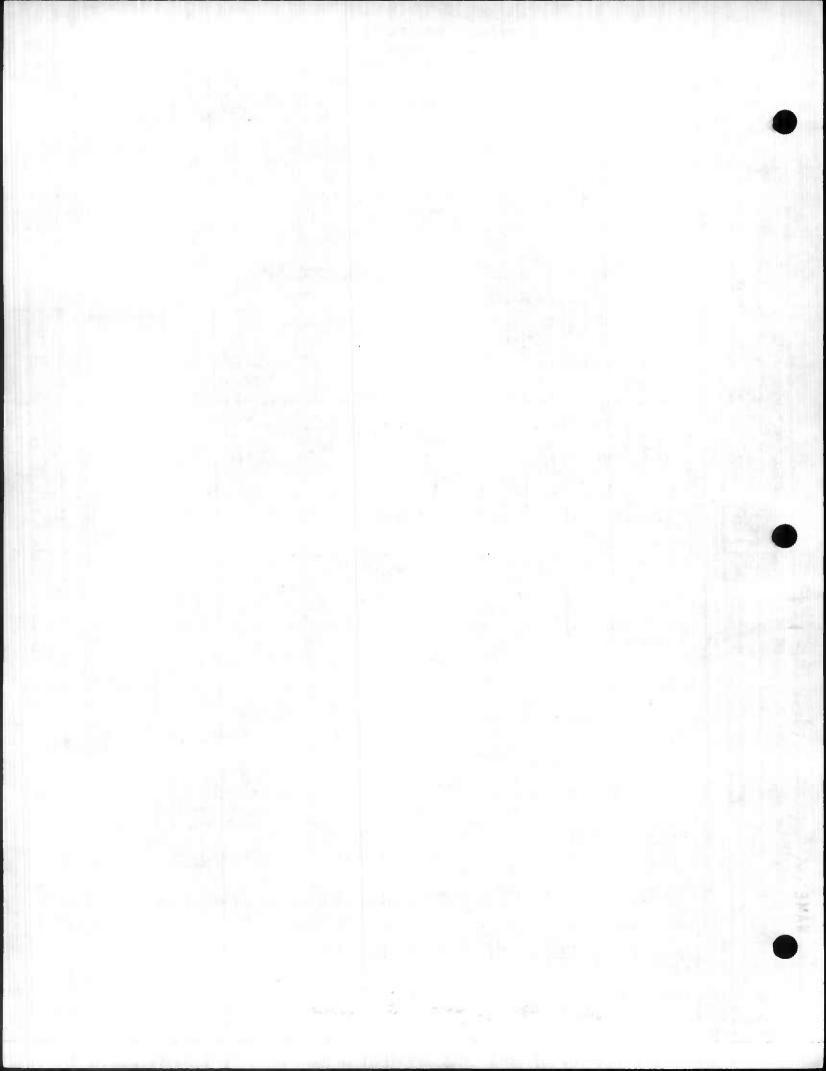


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State of Maryland / Department of Health and Mental Hygiene 99 23626

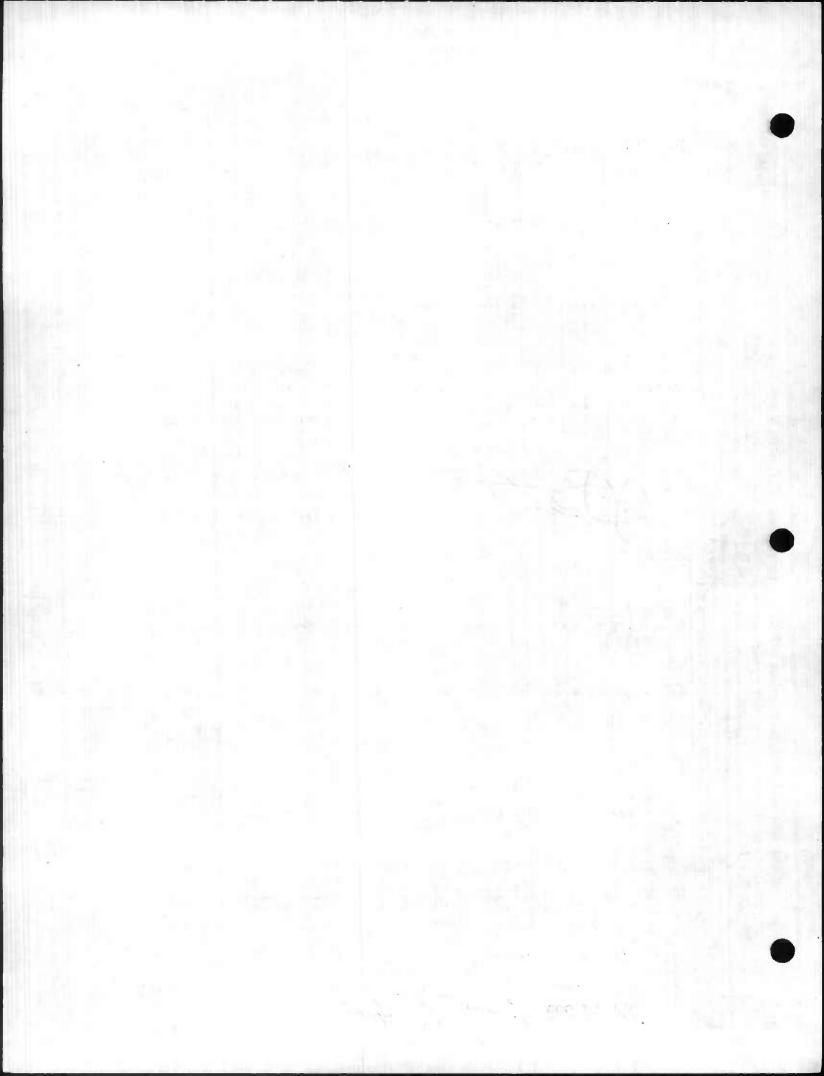
	Certificate of Death Reg. No.								.0020
Physician /Medical	1. Decedent's Name (First, Middle, Last) Norbert Anthony McGee					2. Date of Death Month Day Year 1.455			
Examiner	St. Agnes Hospital Baltimo						ath 4c. County of Death N/A		
Funeral Director	216-12-8046	216-12-8046 XXM 2□F 77 Yrs. Mon				8. Date of Bi (Month, Do JUNE 5	f Birth h, Day, Year) 5, 1922 9. Birthplace (State or Foreig Country) Maryland		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 23e-f show eny injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD N/A	100	a City, Town or Loc Baltimo						10d. Inside City Limits
	10e. Street and Number 1709 Letitia	10f. Zip Code 21230			10g. Citizen of What Country USA			ntry?	
	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceder Agmed Force 4 Yes 2 If Yes, Give Year or Date:		W III		Hispanic Origin? (Span, Mexican, Puerto				
	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give I life. D	ent's Usual Occupind of work done O NOT use retire	during most of wor d)	king	16b. Kind of Business/Industry Shipyard		
	17. Father's Name (First, Middle, Last) Joseph Edward McGee			18. Mother's Name (First, Midd			A 0		
Hospital or Attanding Physician: The law requires that the death certificate be associed by the formal Director: After this certificate has been signed by the ettending physician and so set the funeral director, page 2 should be detached for use as the buriel-transit as in a set the buriel-transit. In the funeral director: After this certification: To Be Completed by Physician/Medical Examiner	4 Donation 5 Other (Special Control of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part III. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part II. Other eignificant conditions of Part III. Other eignificant conditions of Part III. Other eignificant conditions of Part III. Other eignificant conditions of Part III.	a. Due c. Due d. Due d. Due d. Due	death. Do not enter to (or as a consequence of the	Name and Addresses and Address	y ar farce	ty of d. Bal correspiratory a	timore	nc.	
	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. Was	24a. Was an autopsy performed? 24b. Were autopsy find available prior to		
	25. Was case referred to medical 26. Place of Death						completion of cause of death?		ompletion of cause death?
	examiner? 1 Yes No 27. Manner of Death Watural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not be	Accident Could not be Could no							
	29a. Certifier (Check only one) (Check only on								
To the	29b. Signature and title of certifier			29c. License number DJ_5044			29d. Data signed (Month, Day, Year)		
	30. Name and address of person who	completed cause of death	(frem 23a) (Type, F	Print)	St. A	gnes H	ospita	1	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrars 5	Signature	. doo	Ms		-		

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 0 22627

		,	Ce	rtificate of	Death	,	Reg. No.	20	1061
Physician /Medical	1. Decedent's Name (First, Middle, Lauren La	nst)	/	MOORE		2. Date of De Month 0 7	Day	Year 99	3. Time of Death 3. 33 Pm
Examiner	4a Facility Name (If not Institution, gi	Hospital		Willedge 4 Very	4b, City, Town, or L Gen Bu I H Under 24 Hrs.	mie	Ame	Aru	ndel
Funeral Director		IDM XIE	yrs. last birthday, 55 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da DEC . 7		9. Birthpla Countr OHIO	ce (State or Foreign y)
how how	10a. State 10b. County	100	. City, Town or L	ocation				100	d. Inside City Limits
vith the Mer or 28a-f all be notified	MARYLAND ANN	E_ARUNDEL_	GLE	N BURNIE					1 ☐ Yes 2 ☐XNo
3a or 2	10e. Street and Number 8 EASTERN STREET			10f. Zip Code	21061		10g. Citizen of V	What Countr	
15-0020 n 72 hours after death with the Meryland "natural", or litema 23e or 28e-f show edical Examine: must be notified at leted by Funeral Director		12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:	in U,S. 13.	Was Decedent of B if Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp ian, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rac Blac Specify	e - America ck, White, et	c.
T21	15. Decedent's Elementery/Secondery (0-12)		(Give	dent's Usual Occup a kind of work done DO NOT use retire MAKER	during most of work	ing	16b. Kind of Br		estry
	17. Father's Neme (First, Middle, Las)	110112	111111111	18. Mother's Nam	e (First, Middle,			
	HARRY N		COPELAND		ERMA		MAE		IRVIN
N 0 = 5	19a. Informant's Name/Relationship MR. GEORGE A. MO	Type, Print HUSBAND	19b. Meil 8 EA		REET, GLEN				200e) 21061
re, s 1 an f Heal f Heal other	20a. Method of Disposition 1 ☐ Burial XX Cremation 3 [20	b. Place of Disp	osition (Name of matory or other pla	land land	Date /24/99	20c. Location -		
Baltimo bemil. Page Department of important: If it any Injury or	4 Donation 5 Other (Special Signature of Fune Service) Lice		CHESAPPA	KE CREMAT	ION, LLC.	GT PROV	STEVENS		
Balt permit. Depart Importu	21. Signature Pure an Service Close	0/			AVENUE, S				
Physician /Medical	23a. Part / Enter the discording of conshorts, or neutral fure. List only timediate Lause (Finel disease or condition	plications that caused the one cause on each line.		ler the mode of dyi	,	or respiratory e	rrest,		Approximate interval Between Onset and Death
Examiner	resulting in death)		to for as a conse	dneuce ol).		echor			
and transi	Sequentially list conditions,	b. Due	to (or as a conse	quence of):	0	1		I I	
Box 68760, sub certificate be executed attending physician and for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Seven Due t	e a,	quence of)	Artery	O'sea	8e		
. 0 00 -	Pert II. Other significant conditions	contributing to death but not	resulting In the I	underlying cause gi	ven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?
E X 70		enol pri	Pure			10	Yes 2 No	3 Probe	ably 4 Unknown
2 2 8 8	Drabetes	Meditus				24a. Wes	an autopsy omed?	com	e autopsy findings lable prior to ipletion of cause eath?
VITAI Kei lician: The lav certificate has rector, page 2						10	Yes ZENo	10	Yes 2□ No
Of VItal Physician: r this certific and director,	25. Was case referred to medical examiner?	Hannital .			26. Place of Deal	th (Check only	one)		
Pyth's still is the still is th	1 Yes 2 Alongor of Dooth		2 ER/Outpatie	nt 3LI DOA			dence 8 Oth		
Attending or death. ector: Afte by the lune	27. Manner of Death 1 Neturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not to determined	00 - 5111-1	At home, lerm, si	M 1	ryer rk?] Yes 2 □ No		how injury occur Street and Number, State)		Route Number,
Up the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one) 1 Certifying Plant Certifying Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying Ce	nysician: To the best of my miner: On the basis of exar and menner steted.	knowledge, deat nination and/or in	th occurred at the ti evestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and madate and place,	anner as ste and due to t	ited. the cause(s)
To the within To the comple	29b. Signature and title of certifier	4.)) .	29c. Licens	36384		29d. Date signe 7/22/	199	
	30. Name and address of person who BASSIM BASK	. 1	(Item 23a) (Type	Print) OAKWO	DOD RO	1. Q	LEN BU	IENTE	E, HJ. 21061
State	31. Date filed (Month, Day Year)	2. Registrer's S	ignature	land					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #17 PER 7-27-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 13:40 Margie 23 1414 /Medical 4e Facility Name of not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ins more N/A Johns If Under 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 🂢 F 71 Nov 30, California 564-30-2896 **Director** Usual Rasidance of Decedent permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Manyland Department of Health and Mental Hydiene. Important: If Item 27 is marked other than "natural", or items 23s or 23s-f ahow any injury or other traumatic avant, the Medical Examper must be notified as 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No N/A Maryland Directo Baltimore City 10e. Street and Number 10g. Citizen of What Country? 21231 USA 928½ Fell Street Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Giva Yaar or Datas: 14. Rece - Amarican Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 11. Maritai Stetus 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) State of Maryland Banking Commissioner 4 vrs 18. Mother's Name (First, Middle, Maiden Sumema) 17. Fathar's Nama (First, Middle, Last) Ull 1 man S. Jack Muller Hellman Marjorie 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. informent's Name/Relationship (Type, Print) 928½ Fell Street, Baltimore, Maryland 21231 (Husband) Dr. Steven Muller, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 MCremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 7/27/99 Baltimore, Maryland Green Mount Crematory 21. Signature of Funeral Service Ligensee

Martin D. Lawson 22. Nema end Address of Facility any lr Mitchell-Wiedefeld Funeral Home, Inc. PIGLICIT D. Lawson

6500 York Road, Baltimore, Maryland 21212

23a. Pert1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Appr Approximete Intervel Between Onset and Deeth **Physician** /Medical immediate Cause (Finel 48 hours diseese or condition resulting in deeth) Examiner bstructive Pulmonary Physician/Medicai Examiner attending physicien and for use es the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiete cause. Enter Undarfying Cause (Disease or Injury that initieted events Box 68760. Due to (or es a consequenca of): resulting in death) Last 50 23b. Did tobecco use contributs to the cause of death? Pert II. Other stanificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. o the signed by t 1 Yes 2 No 3 Probably 4 Unknown ۵ Records, P 24b. Were autopsy findings available prior to Completed 24a. Wes an eutopsy performed? Deen complation of cause of deeth? has The 1 Yes 2 No 1 ☐ Yas 2 No certificate Division of Vital or Attanding Physician: 25. Was case rafarred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerai 28e. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 1 Naturel 5 Pending invastigetion 1 Yes 2 No death. Director: / 2 Accidant 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) efter 4 ☐ Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) and menner as stated.

Medical Examiner: On the best of exeminetion end/or invastigetion, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) end menner stated. edicai 29a. Certifier (Check only one) within 2 29c. License number 29d. Data signed (Month, Dev. Year) 29b. Signeture end title of cartifier 0 Brodie, MD RES

completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

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Smolie

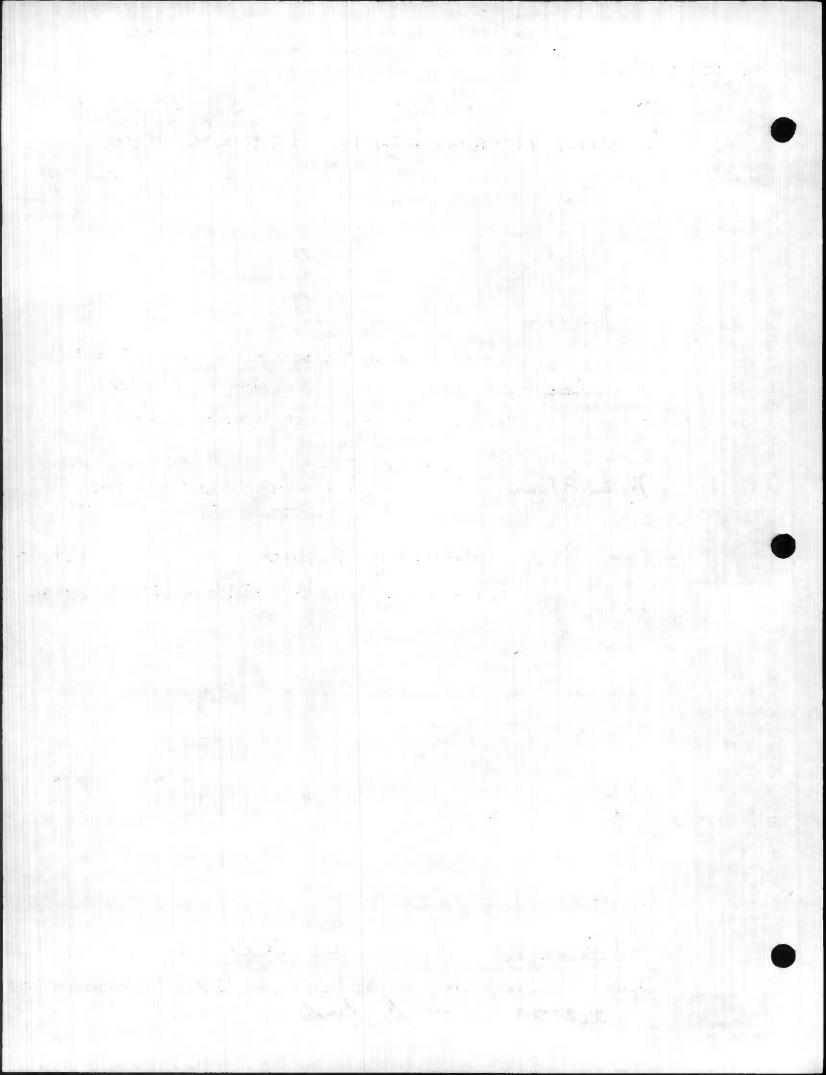
JUL 27 1999

Hopkins Harpital, 600 N. Wolfe St., Baltimore, ND 21287

State Registrar 30. Name and address of person

anie

31. Dete filed (Month, Day, Year)

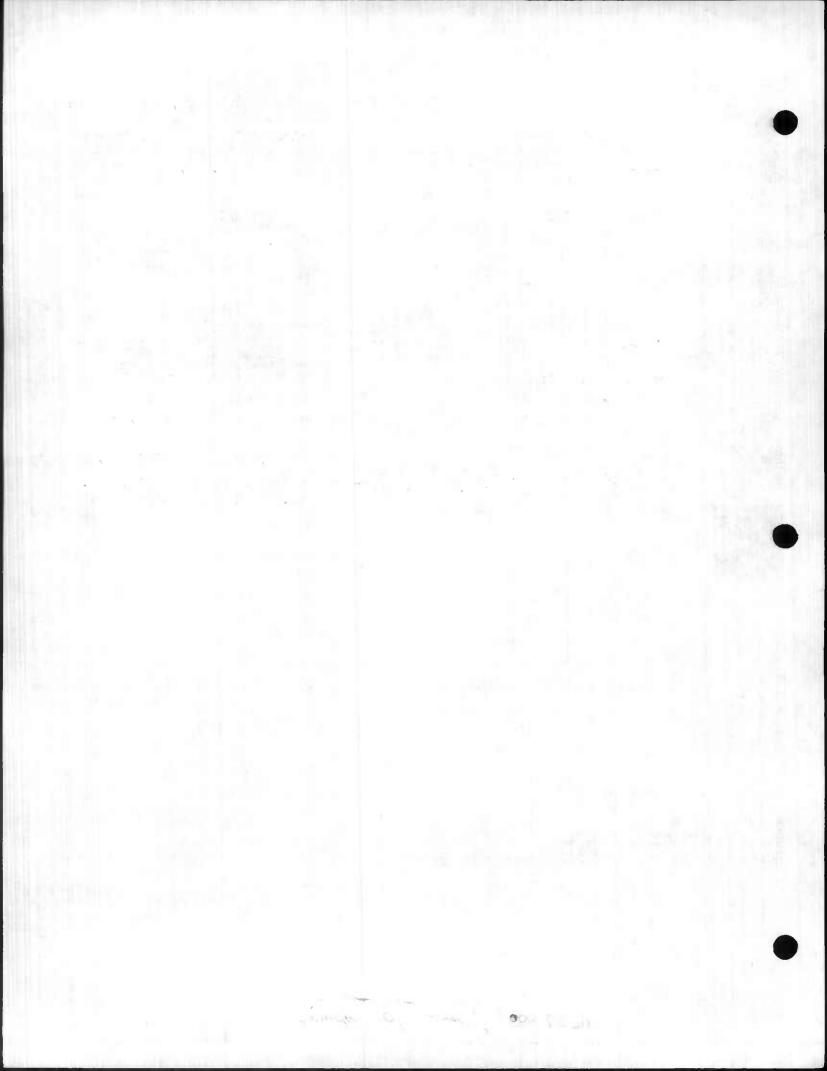


State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** GUIDO MACCALLINI July 25, 1999 5:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Commons Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 18,1922 9. Birthplace (State or Foreign Country)
Ohio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 10km 20 F Yrs. 291-14-7304 76 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits worle permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hydene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 TYAS 2 No Director Perry Hall Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21236 United States Funeral 8620 Silver Meadow Lane 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, atc. 11 Marital Status TEYes 2 No if Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à White 3⊠ Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Millwright Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Angelina Mazzulli Pasquale Maccallini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Maccallini/Son 8620 Silver Meadow Lane Perry Hall, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremation 3 □ Removel from State 4 Donation 5 Offer (Specify) Oal Lawn Cemetery 7/28/1999 Baltimore, MD 21. Signatu F 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one cause on the shock or heart feiture. Approximete Intervei Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myscerdid Lours Examiner Examiner physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): signed by the e Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown artery Records, þ The lew requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 a 1 Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificalethy filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2N No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of tnjury 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier July 26, 1999 chor D-40521 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkers Avenue DR. OCHANEY MD thmore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

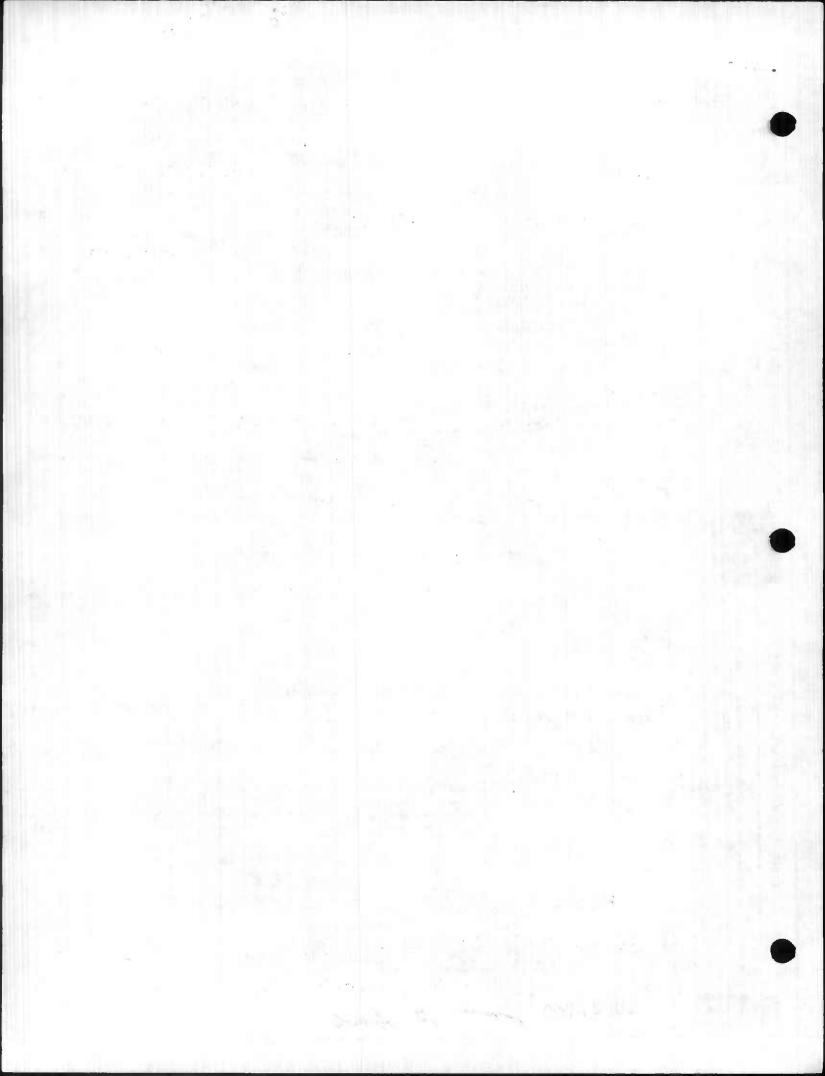
A-141

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 99 23630

	-				Certificate o	f Death	Re	ig. No.	_	0000
Di		1. Decedent's Neme (First, Middle, L.	nst)				2. Date of Death	Davi	Year	3. Time of Death
	ysician Medical	Alma Miller					July 26	, ^D 1 999	1 041	9:15 AM
	aminer	4e Facility Name (If not Institution, gi	ve street and number)		4b. City, Town, or	Location of Death	4c. County	of Death	
		The Hospice Hou	ıse			Linthic		Anne		
Fun Dire		218-40-8039	Sex 1 □ M 2 2 F	ge (In yrs. last b	Months Day		8. Dete of Birth (Month, Day, Aug. 9,	Year) 1904	9. Birthp Coun Mar	lece (State or Foreign try) y l and
PG &		Usuel Residence of Decedent 10e. Stata 10b. County		10c. City. To	wn or Location				1	0d. Inside City Limits
Manyl	10	Maryland Baltin	noro		Baltimore					1 ☐ Yes 2 🂢 No
28 g	Director	Maryland Baltin	101 6		10f. Zip Code		10	Og. Citizen of V	What Coun	dry?
with a	4 0		rĉle			239		Unite		
Joseth 72 2	Funeral	11. Meritel Status	12. Wes Deceden	t Ever in U,S.	13. Wes Decedent of If Yes, specify Cu		pecify Yes or No-	14. Rec	e - Americ	an Indian,
21215-0020 d within 72 hours after death with the Manyland glene. rr than "natural", or harms 23a or 28s-4 ahow	و ا	1 ☐ Never Merried 2 ☐ Merried 3 🛱 Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 K If Yes, Give Year or Detes	No	If Yes, specify Co		to Rican, etc.)	Specify	ck, White, W	elc. hite
15-002 72 hours	r, pe Vedcel	15. Decedent'a E (Specify only highest gr		160	a. Decedent's Usuel Occ	cupation	deina	16b. Kind of B	ualness/inc	Justry
T 5	aldu ple	Elementery/Secondary (0-12)	College (1-4or	5+)	(Give kind of work don life. DO NOT use reti					
	Cor	8			Homema			Own I		
Maryland d 2 should be file th and Mental Hy 7 is marked oth	Be C	17. Father'a Name (First, Middle, Las	")			18. Mother'a Na	me (First, Middle, A		10)	
laryland 2 2 should be filed and Mental Hygi	To	Henry Boyce				Mary	Unknow			
2 = =	Taur.	19a. Informent'a Neme/Reletionship			b. Meiling Addresa (Stre					
C = 0	ě	Mark Gaertner /	Grandson		8393 Scarle					
29.0	Injury or othe B.	20e. Method of Disposition 1 X Buriel 2 Cremetion 3 C 4 Donetlon 5 Other (Speci		cemen	n Mount Cem	place)	7/28/99 B	altimo		
Baltim permit. Pag Department Important: I	any Inj pnce.	21. Signature of Funeral Service Lice	nsee /		Leonard J 5305 Harf	ress of Facility Ruck, II ord Road	nc. Funer Baltimor	al Home	e 21214	
- 12		23a. Pert1. Enter the displace, or born shock, or heart feil a e. List only	core cause on each	d the deeth. Do					-	Approximata Interval Between
Physic	ian			1						Onset end Deeth
/Med	_	fmmediate Cause (Finel disease or condition	can	an sti	w hea	it for	ilurs	2		years
Exami		resulting in deeth)	a	Due to (or as a	consequence of):		ilur			1
ס	e e		isch	emic	card	10 nu	opat	her		years
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e axe		Sequentielly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events					•		1	
68760, ficate be an g physician	es the bur	thet initiated events reaulting in death) Last	C	Due to (or es a	consequence of):					
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death cert death cert e attendin	ary		d							
. 0 0	sici	Pert II. Other significant conditions	contributing to death	but not resulting	in the underlying cause	given in Pert f.	23b. Did to	bacco una co	ntribute to	the cause of death?
dS, P.O. uires that that de signed by the a	etached for use a Physician/M	advanced de	men tic	2 61	lateras	0	1 🗆 Yı	2 200	3 Prol	bably 4 Unknow
es th	e s	acourted a	1	~/ 5	70,000					
Records, P.O he law requires that tha has been signed by th	Completed	stesis devin	atitis	and	cellu	litis	24a. Wes ar	n autopsy ned?	av	ere autopsy findings allable prior to
Hes be	2 sh		7	7	1.	+ 10			of	mpletion of cause death?
E 9 -	Com	peripheral	vascu	laro	usease +	Phrilipa	1 Ye	s 2 No	10	Yes 2□ No
Vital I	Be 6	25. Was case referred to medical examiner?			7	26. Place of De	ath (Check only on	θ)		
<u>→ 5 .00</u>	E 0	1 ☐ Yes 2 No	Hospital: 1 Inpat	ient 2 ER/O	Outpatient 3 DOA	Other: 4 Nursing H	lome 5 Reside	nce 6 Oth	er (Specif	n HOSpice
VISION O Attanding Ph r death. ector: After th	e funeral	27, Manner of Death Natural 5 Pending Colored investigation	28a. Date of Inj (Month, Da	ury ay Year) 28b.	Time of fnjury M 1	juryat vork? □ Yes 2 □ No	28d. Describe ho	w injury occur	red	House
Division or Attanding after death. Director: After	led in by the funer Certification:	3 ☐ Suicide 6 ☐ Could not to determined	286. PIECE OF IF	njury - At home, f dc. (Specify)	lerm, atreet, fectory, office	9	28f. Location (St. City or Town		per or Rure	Route Number,
To the Hospital within 24 hours To the Funeral	completely filled in by the funeral Medical Certification:	29e. Certifier Certifying Pl (Check only 2 Medical Exa-	nysician: To the best miner: On the basis of and manner s	of my knowledg of examination a teted.	e, death occurred at the nd/or investigation, in my	time, date end place y opinion, death occu	e, end due to the ca arred at the time, do	use(s) and ma ete and place,	anner as a and due to	lated. the cause(s)
To the Within	Me Me	29b. Signeture and title of certifier	_	//	29c. Lice	nse number	25	9d. Date signe	d (Month,	Day, Year)
- 3 -	0	un	ne	5	cci	04195	5	7-	26	199
	-	30.Namerand address of person who	completed cause of	death (Item 22a)	(Type Print)	21 0 0	1 00	/	0	Lann
		Alaeres Dri	2 MM	479	Trum none	Holo Po	1 Leve	Vva.	IVI	W M
	State	3 Date filed (Month Day Year)	32. Realst	rar'a Signature	1000131	10010			170	2
Re	gistrar	JUL 2 7 199	9 June	me to	1. Some	/				



Please Type or Print in Biack Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death **Physician** Month Doris Jean Matthew July 25, 1999 6:00 p.m. /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Franklin Square Hospital Center Rosedale Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2**X**F Months 212-34-7623 Director Yrs. 67 March 1, 1932 Maryland Usuel Residence of Decedent death with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show "natural", or items 23s or 28a-f showed cal Examiner naunt be notified at Completed by Funeral Director Maryland Baltimore 1 Yes 2 No Essex 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 542 Back River Neck Road 21221 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Peges 1 and 2 should be filed within 72 hours after cent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or iter
Inty or other traumatic event, the Medical Expension Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🖾 No Specify: Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Clerk Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Robert A. Parrott Mary E. Stansbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary E. Brightwell (daughter) 803 North Essex Avenue, Essex, Maryland 21221 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XX remetion 3 ☐ Removel from State permit. Pege Depertment of Important: If any Injury or once. Donetion 5 Other (Specify) 7/28/99Baltimore, Maryland Green Mount Crematory ere of Funeral Service Licensee 22. Name end Address of Fecility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. 23a. P. rt1. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final probable myocar (
Due to (or es e consequence of): myocardial diseese or condition resulting in death) **Examiner** Physician/Medical Examiner hypertension burial-transit The law requires that the deeth certificete be executed Sequentielly ilst conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or es e consequence of) the Dus to (or as a consequence of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? hypercholesterolemia 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed by page 2 should be 24e. Wes an eutopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? tobacco abuse 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical exeminer? 28. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 201No this in by the funeral 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After 1 Neturel 5 Pending Investigation To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: After completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ SuicIde 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a, Certifier **Examiner: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piaca, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) D0051349

pleted cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture

9101 Franklin

Square de Sorte 205 Balt, MB 21237

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records.

of Vital

Division

DHMH 16 Ray 6/95

State Registrar

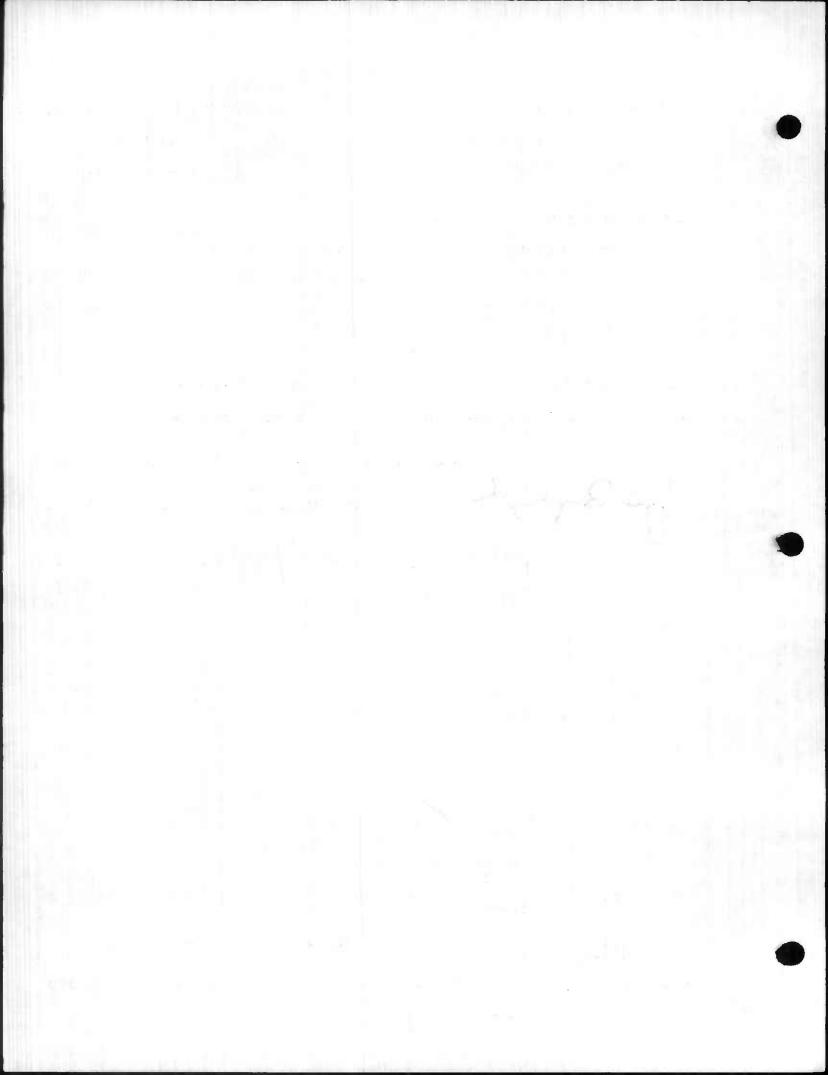
30. Name end eddress of person who co

27

Veronica 31. Date filed (Month, Dey, Year)

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	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Heelth and Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s 4 show any injury or other treumentic event, the Medical Expression must be notified at PARE.	Director	Md.
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	Physician /Medical Examiner		Immedia diseese resulting
	outed and ransit	aminer	Sequent

4b. City, Town, or Location of Deeth 4c. County of Deetl lity Neme (If not Institution, give street and number) riner Health of Bel Bel Air Harford Air If Under 1 Yeer | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) Security Number 7. Age (In yrs. lest birthdey) 1 M 2□ F Months Days Hours Min. 01 Yrs. 1908 Ukraine Sept. 5-28-8368 esidenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Harford Bel Air eet end Number 10f. Zip Code 10g. Citizen of What Country? 707 Country Village Drive 21014 U.S. of America 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Widowed 4 Divorced 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Commerical Architentery/Secondery (0-12) Coilege (1-4or 5+) 4 Architect ectural Planning 18. Mother's Neme (First, Middle, Maiden Surname) er's Name (First, Middle, Last) Duda rl Mark Maria 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) orment's Name/Reletionship (Type, Print) 2904 Louise Ct. Forest Hill, Md. 21050 rew Mark (Son) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete thod of Disposition July Burial 2 Cremetion 3 Removel from Stete St' Mary's Ukr. Catholic29 Elkins Park, Pa. Donetion 5 Other (Specify) 22. Name and Address of Fecility
W. Dabrowski-Chojnacki F.H.'s P.A. neture of Funeral Service Licensee 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, social accordance of the practical control of the control of ate Ceuse (Finel or condition g in deeth) /week Lros ensis Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia Alzheimers Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy TLI Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 4 ursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 1 Neturel 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end pieca, and due to the cause(s) end menner steted. 29e. Certifier

State Registrar 29b. Signeture end tiple of certifier

31. Dete filed (Month, Dey, Yeer)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

North

32. Registracs Signeture

DHMH 16 Rev 6/95

The law requires that the death certificete be exe

signed by t

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After

To the Hospital or within 24 hours aft To the Funeral Di completely filled Ir

Division of Vital Records, P.O. Box 68760,

FREDERICK

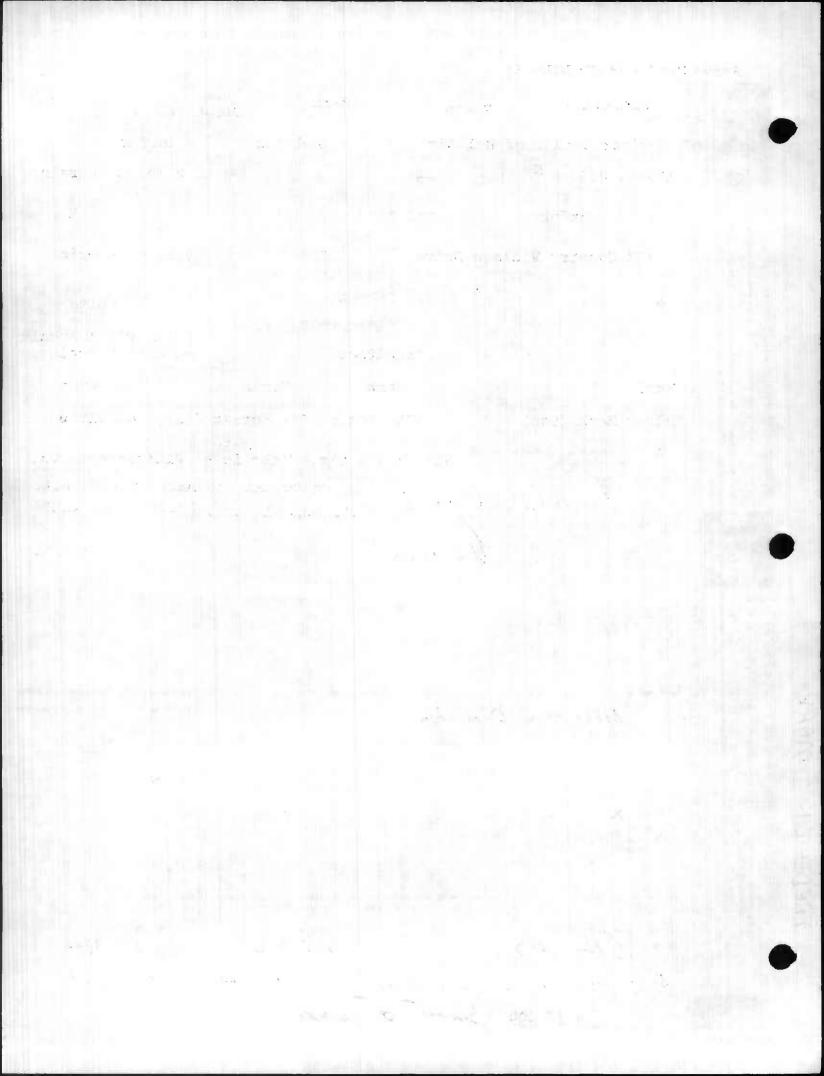
29d. Dete signed (Month, Day, Year)

3. Time of Death

PM

29c. License number

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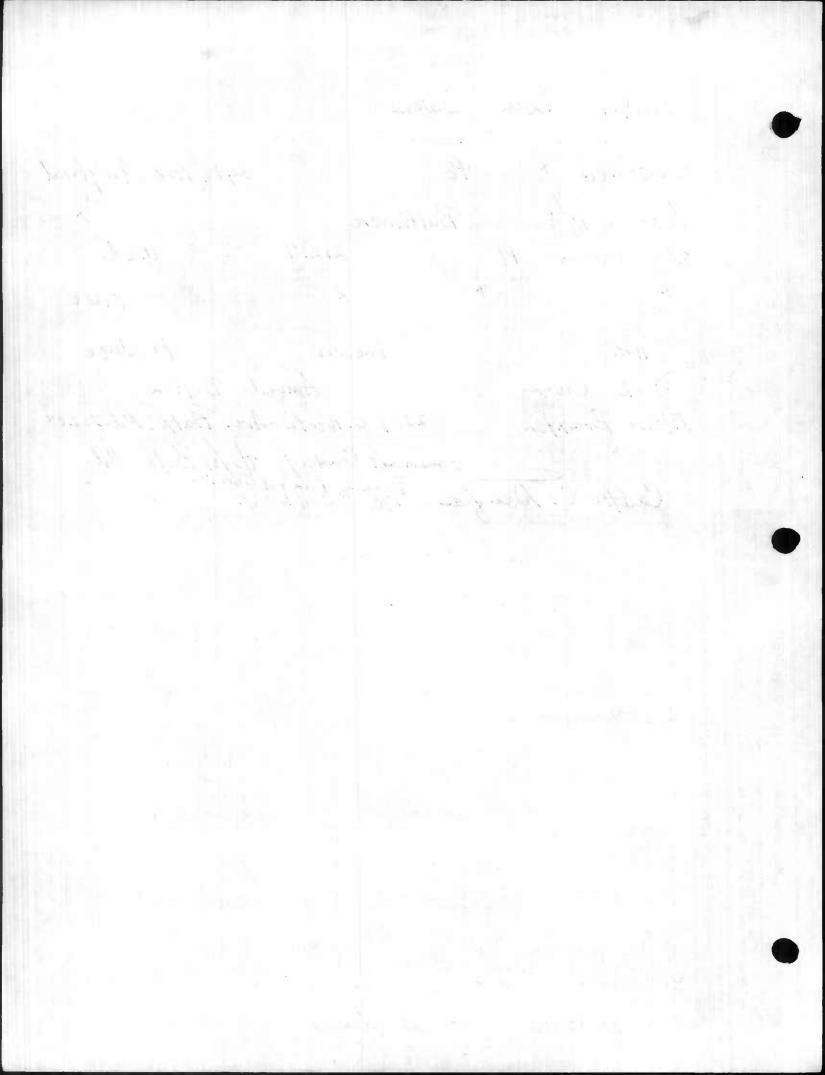


Owe	ns		State of Maryland	Certificate of		Reg. No. 9 9	23633
	Physiciar /Medica	1. Decedent's Name (First, Middle, L	1 1	vens	Mo	e of Death oth Dey	3. Tima of Death 1999 01:42 PM.
	Examine	4a Facility Name (If not institution, g			4b. City, Town, or Location of	of Death 4c. County	
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	work and a	Usuel Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Location		7	10d. Inside City Limits t 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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5-0020	List after Coast with the maryan	11. Marital Status **Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 Yes 2 10 Vo II Yes, Give Year or Dates:	S. 13. Was Decedent of H If Yes, specify Cubs	lispanic Origin? (Specify Ye an, Mexican, Puerto Rican, o Specify:		ca - American Indian, ck, White, etc.
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Maryland	and Mental Hygiene. is marked other than sumatic avent, trail.	17. Eather's Neme (First, Middle, Las	ii) Ieas		18. Mother's Name (First, Amanda	Middle, Maiden Sumen Belton	ne)
Mar	the and	19a. Informant's Name/Relationship		19b. Meiling Address (Street	and Number or Rural Route	Number City or Town,	, Stele, Zip Code) Ad-21213
	- 1 2 2	20a. Method of Disposition	20b. Pla	ace of Disposition (Name of imetery, cremetory or other place	Dite	20c. Location	- City or Town, Stata
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Baltimore,	Department Important: Important: I any Injury oppose	21. Signeture of Funeral Service LS		2. Name and Addre		vice	
		23a. Part1. Enter the disease, or co- shock, or heart failure. List onl	nplications that caused the death y one cause on sech line.	. Do not enter the mode of dyir	ng, such es cardiec or respir	etory arrest,	Approximate Interval Between
и.	hysician /Medical ixaminer	Immediate Cause (Final disease or condition resulting in deeth)	. Serzum	is a consequence of):			Onset and Death
Box 68760,	_ = =	Cause (Disease or injury that initiated events resulting in death) Last	С.	as a consequence of): as a consequence of):			
. 4	e atte	Pert II. Other significant conditions	contributing to death but not resul	Iting in the underlying cause giv	ven in Part I. 23	b. Did tobacco usa co	entribute to the cause of death?
0 3	£ 4 5	+ATTY Live				1 Yes 2 No	3 Probably
I Records, P	2 8 2 8					a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
= "	certificate rector, pag	25. Was case referred to medical			26. Place of Death (Chec	k only one)	1 Yes 2 No
of Vita	this cert al direct	examiner?	Hospital: 1 Inpatient 2 E	ER/Outpatient 3 DOA Oth			ner (Specify)
Division o	S S S S	27. Manner of Death 1 Netural 5 Pending 2 Accident investigati	on (Month, Day Year)	28b. Time of Injury M 28c. Injury M 1	y at 28d. De k? Yes 2 □ No	scribe how Injury occur	rred
Divis	al Director: / lied in by the Certificat	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office	28f. Loc City	eation (Street and Numi y or Town, State)	ber or Rural Route Number,
I the Hosoftal	C 2 6	(Check only one) 2 Medical Ext	hysician: To the best of my know milner: On the basis of examinati and manner stated.	on and/or investigation, in my o	pinion, deeth occurred at th	e time, date and placa,	and due to the cause(s)
100	Total	29b. Signetyte and title of certifier	D. (1/2.10)	29c. Licens			ed (Month, Dey, Year)
		30. Name and address of person who	Opposed cause of death (from		C.M.E.	July	18, 1999
		30. Name and address of person with MANA WITS 31. Dete filled (Month, Day, Year)		enn Street, Bal	Ltimore, Mary	land 21201	
	State Registrar	1111 9 79 4		A Some			

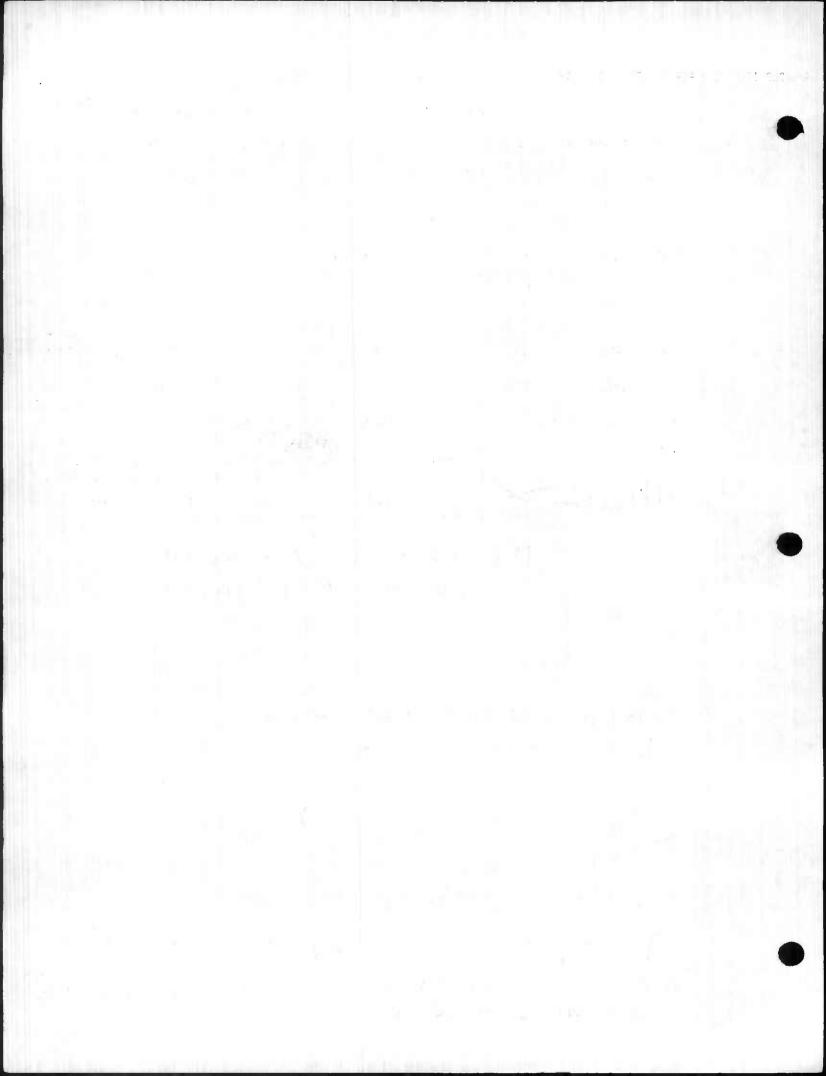
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NDED ITEM #	20h	PER FH G774 8/2/99 A	State of Ma	aryland /		rtment tificate			d Me		giene 9 9 Reg. No.	2	3634
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/Med Exam		4a. Facility Name (If not institution,		ear son			4	b. City, Town		July ation of Death	25, 4c. County	99 of Death	AL HARL
LXdiii	II ICI	Irvington K	nolls Nurs	sina C	ent	er		Balt	imo	re	NA		
Funera Directo	_	5. Social Security Number 218-075273		e (In yrs. iast b		If Under 1	Year Days	If Under 24		B. Date of Birt (Month, Day 08-07			lace (State or Foreig stry) J
pu *_		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Loc	ation						1	0d. Inside City Limits
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the 1	Director	10e. Street and Number		Dare	2 2 1110	10f. Zip C	ode				10g. Citizen of	What Coun	
3a or	0	2008 Rayner A	venue				217				USA		,
ter des	by Funeral	11. Maritai Status 1 Never Married 2 Marrie 3 Widowed ***D**Divorced	12. Was Decedent E Armed Forces? d **Yes 2 \(\text{N}\) If Yes, Give Year or Dates:		lf lf	/as Deceder Yes, specify	y Cubar	n, Mexican, P	? (Spec uerto R	ify Yes or No- ican, etc.)	Bia	ca - Americ ck, White,	etc.
5-0 72 ho	ted	15. Decedent's	Education	168	a. Decede	ent's Usual	Occupa	tion	To a serie de la constante de		16b. Kind of B	usiness/Inc	dustry
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Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours at becament of Health and Mental hygiene. mportant: If item 27 is marked other than "natural", or ny injury or other traumatic event, the Medical Englands.	To Be	17. Father'a Name (First, Middle, L Walter	Pearson					Elle	n		Maiden Sumar Wagr	ier	
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or Attanding Physician: The law requires that the deeth certific after deeth. Director: After this certificate has been signed by the attending of the funeral director, page 2 should be detected for use as	Completed	Duod	ENAL	ML	C 8	P	_		_	24a. Was perfo	an autopsy med?	ave	ere autopsy findings ellable prior to mpletion of ceuse death?
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To the Hospital of within 24 hours a To the Funeral D completely filled I	edical	29a. Certifier 1 Certifying (Check only one) 2 Madical Ex	Physician: To the best of taminer: On the basis of and manner stat	examination ar	e, death nd/or inve	occurred at estigation, in	the time my op	e, date and p inion, death o	lace, an	d due to the d at the tima, d	ause(s) and m data and placa,	anner as st and dua to	ated. the causa(s)
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		MADURA	· L. 10	ABHA	KA	FRN	15) 2	111	504	PRK	EM!	RUAT
St	ate	31. Date filed (Month, Day, Year)		r's Signature	-	1	,			Ú.	211	1	w



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) rennacc 12 Jul 4c. County of Death 4b. City, Town, or Location of De ath 4a Facility Neme (If not institution, give street end number) rath 8. Dete of Birth (Month, Dey, Year) 9-12-1907 9. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Min 1□M 21 F Months Deys Hours 91 216-46-4233 Italy Usuel Residence of Decedent 10c City Town or Location 10a State 10h County 10d. Inside City Limits n/a Baltimore 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6712 Railway 21222 USA Avenue 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 ☐ Never Merried 2 X Merried White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16s. Decedent's Usuel Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home 5th 18. Mother'e Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Giovanni Canelli Filomena Celozzi 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Name/Reletionship (Type, Print) Spouse 6712 Railway Ave., Baltimore, Maryland 21222 Ambrose Pennacchia 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 M Buriel 2 ☐ Cremetion 3 ☐ Removel from State 7/24/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Holy Redeemer 21. Signeture of Funerei Service Licensee 22. Neme and Address of Feclity Joseph N. Zannino Jr., Funeral Hm Maria 263 S. Conkling Street Baltimore Maryland 21224 23a. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Deeth Immediete Cause (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Lest Due to (or es a consequence of): ura Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy retention, anemia 25. Was lase referred to medical examiner? 1 ☐ Yes 2 ☐ No TUYes 20 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Netural 5 Pending

Physician /Medical Examiner

Department o Important: If any injury or

Physician

/Medical

Examiner

MD

Director

Funeral

p

Completed

Funeral

Director

the Maryland

nit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylas adment of Health and Mental Hygiens. As adment of Health and Mental Hygiens then ortant: If feer 23a or 28a-f show fortent: If feer or 21a marked other than "natural", or frems 23a or 28a-f show in Jury or other traumatic avant, the Medical Evanter must be nutilist.

Baltimore, Maryland 21215-0020

Physician/Medical þ Completed

Be

Certification: To

edical

ician and buriel-transit physician s the buriel 88 9SI funeral director, After this 24 hours after deeth. • Funeral Director: Af

that the death certificate be axec

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Investigation

6 Could not be

28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Geritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

2 Accident

3 Sulcide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

ted cause of deeth (item 23a) (Type, Print)

31. Dete filed (Month, Day, Year)

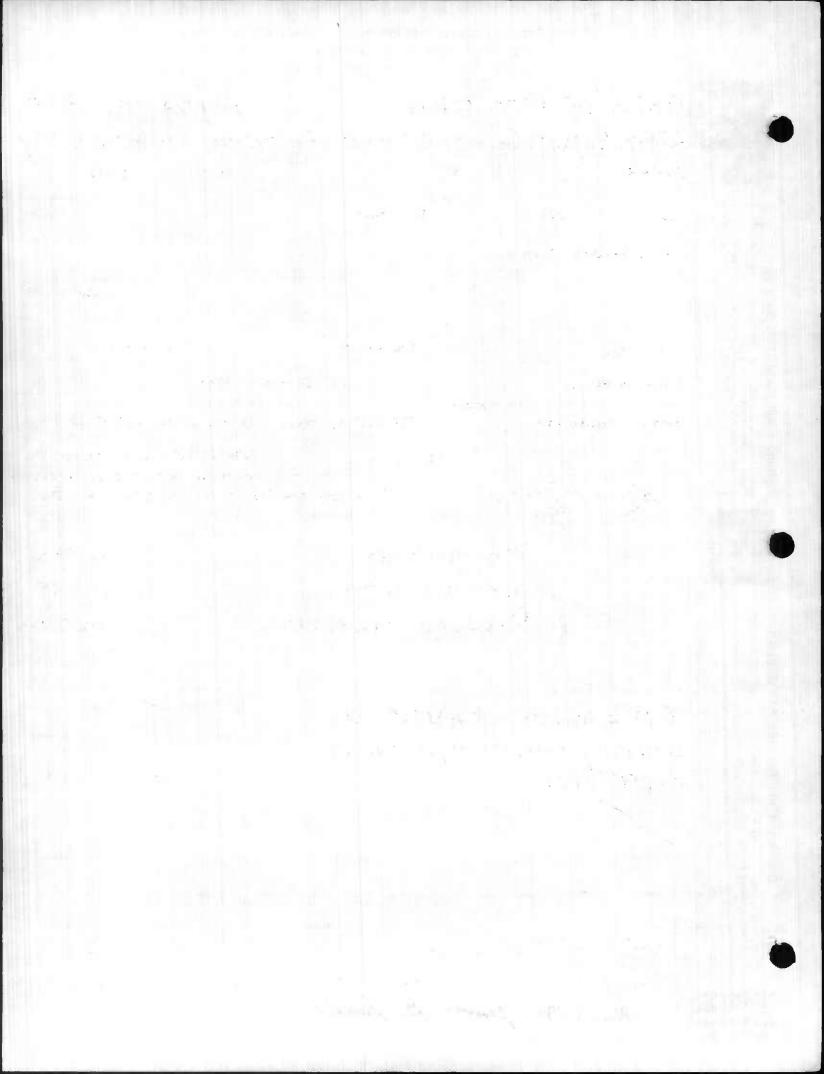
JUL 2 7 1999

32. Registrer's Signeture

Hypkins Boyvie Circle Bultimore mozizzy 5505

State Registrar

completely 1 within 2 To the To the

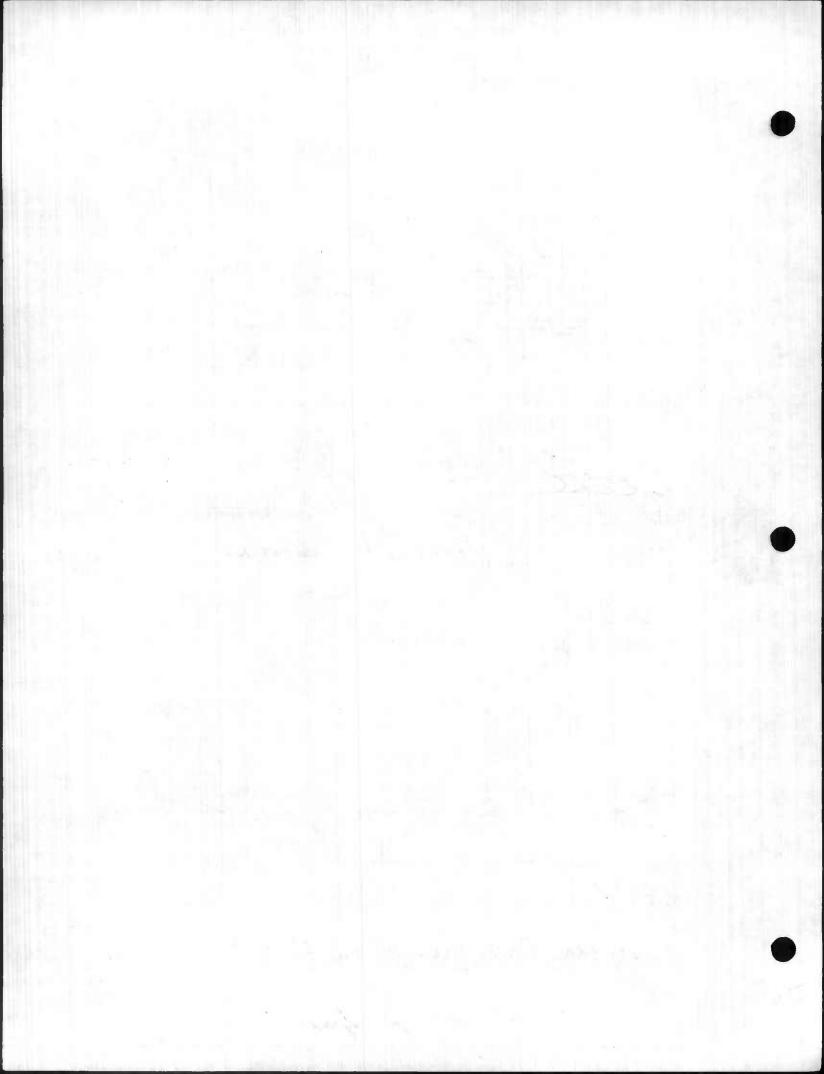


State of Maryland / Department of Health and Mental Hygiene ()

	Certificate of Death	Reg. N	33 636	36		
D	Decedent's Neme (First, Middle, Last)	2. Date of Death Month D	Vant Vant	Tima of Death		
Physician /Medical	Barbara Stevens Pieper	July 2		:15 AM		
Examiner	4e Facility Name (If not institution, give street and number) 4b. City, Town, or L	ocation of Death 4	c. County of Death			
	2012 Dumont Road Timonium		Baltimore			
Funeral Director	5. Social Security Number 215-50-4643 6. Sex 1 Months 1 M	8. Dete of Birth (Month, Day, Yea Nov. 27 1	9. Birthplace (Country) 954 Maryla	State or Foreig		
fland	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location		10d. In	side City Limits		
Mary tor	MD Baltimore Timonium		11	Yas 2 No		
vith the Mar tor 28a-f e	10e. Street and Number 10f. Zip Code	10g. C	Itizen of What Country?			
h wit	2012 Dumont Road 21093	U	SA			
72 hours after death with the Maryland natural; or thems 23a or 28s-f show after Examiner must be notified at steed by Funeral Director	11. Merital Stetus 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto If Yes, Sive Yaer or Detes: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Raca - American Inc Bleck, Whita, atc. Specify: Wh			
5 1 3	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b.	Kind of Business/Industry			
filed withir Hygiena. ther than ent, tre the	12 4 Teacher	E	ducation			
ETSE a		ne (First, Middle, Meide	· ·			
2 should be and Mental is marked of aurmatic ev	John B. Littleton S. Vir	ginia Meye	r			
and and series	19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Ru)		
s 1 and 7 Health item 27 other tr	John D. Pieper/husband 2012 Dumont Road, T					
8077	20a. Method of Disposition 1 Surial 2 Cremetion 3 Removel from Stete	Dete 20c.	Location - City or Town, S	itate		
nit. Pages artment of I ortant: If its Injury or o	4 □ Donetion 5 □ Other (Specify) Dulaney Valley Memorial	Gardens T	imonium, M	D 2109		
permit. Pag Department Important: I any Injury o	21. Signature of Funeral Service Streets 22. Name and Address of Facility Lemmon Funeral H 10 W. Padonia Rd.	Home d., Timonium, MD 21093				
	Michael J. Flagle 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart feiture. List only one cause on each line.		Appr	oximate val Between		
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth) a. Hodghus hypuphurn Due to (bres a consequence of):	d	6	yrs.		
tificate be executed of physician and as the burial-transit Aedical Examiner	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		5 1 1 0			
	Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of):					
e attendin od for use						
the d sched	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacc	2 No 3 Probably			
per see		24a. Was an aut performed?	evailable	utopsy findings e prior to ion of cause ?		
The law ate has the page 2 s		1 ☐ Yes	. /	2 No		
certificate rector, pag	25. Wes case referred to medical 26. Piaca of Dea	ath (Check only one)	2010	20140		
	examiner? Hospitel: Other:	lome 5 Residence	6 DOther (Specify)			
Physical distriction	1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing H 27. Menne of Death 28a. Dete of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how in				
ual or Attending P rs after death. al Director: After t led in by the funers Certification:	2 Accident investigation 3 Suicide 6 Could not be determined experiment		and Number or Rurel Rou	ite Number,		
s after al Direction bed in b	4 Homicide building, efc. (Specify)	City or Town, Ste	16)			
Hospi 24 hou Funer tely fill	29e. Certifier (Check only one) 1. **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2. **Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place 2. **Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place 2. **Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place 2. **Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place 2. **Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place 2. **Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place 2. **Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place 2. **Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place 2. **Medical Examiner: On the basis of examiner: On the basi			cause(s)		
within To the comple	29b. Signeture and title of certifier 29c. License number		Dete signed (Month, Dey,	Year)		
	I Conald attrasio, 0-2809	77 '	7/26/99			
	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)	v . 0	+/-			
	Ronald Attanasio, M.D. 1576 Merritt Blvd.,	, Ste. 14,	Balto., MD	21222		
State	31. Dete filed (Month, Dey, Year) 32. Registrer's Signature					

Registrar DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 9 9

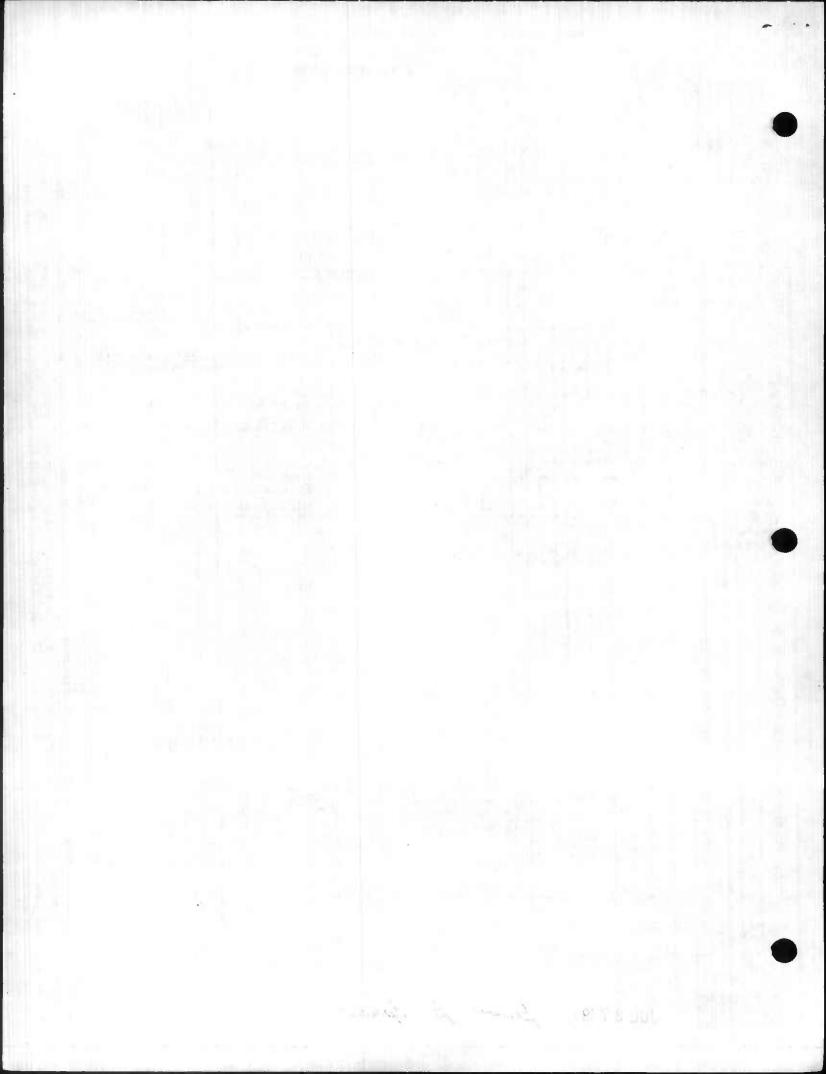
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** YVICO 10:07 A 25 NL /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner OWCORE absortal who Seneral umbl 5. Social Security Number 7 Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2 8 F Days Hours 75.56.5170 Director BARBADOS Usual Residence of Decedent with the Maryland 10a Stete 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Examinar must be notified at 1 Yas 2 No Director MO OLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5018 ROUND PLACE TOWER 21044 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or frems 23a any Injury or other traumatic event, the Medical Example 1990. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
N Yes, Give
Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use regired) 16b. Kind of Business/Industry WEST CHESTER Elementery/Secondary (0-12) College (1-4or 5+) GRADE NIA 1TH EEPING UNIVERSITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) WATSON KUUTH AUBURN MRICE 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PRICE DAUGHTER 1402 KEDWOOD (HESTER 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location · City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State PHILADELPHIA MEMORIAL PARK 1-31-99 WEST CHESTER, PA. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecilit VAUGHN C. GREENE FUNDRAL SERVICE 5151 BAUTO. NATT PIKE, BAUTO. 21229 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or hear failure. List only one cause on each line. Approximata IntervsI Between Onset and Deeth **Physician** Pibrillation /Medicai Immediate Cause (Fins) disease or condition resulting in desth) one hour Examiner Due to (or as a consequence of) Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initisted events resulting in death) Last Due to (or as a consequence of) physician at the burial Box 68760. Due to (or es a consequence of): 88 030 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown terns Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Netural 5 Pending investigation 1 ☐ Yas 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, deta and place, and due to the cause(s) and manner as ststed.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and menner steted. edical completely (Check only one) To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILLES 3460 GARY Ellicett Cante 31. Dete filed (Month, Day, Year) 32. Registrer's Signetyre State JUL 2 7 1999 Registrar

AH6

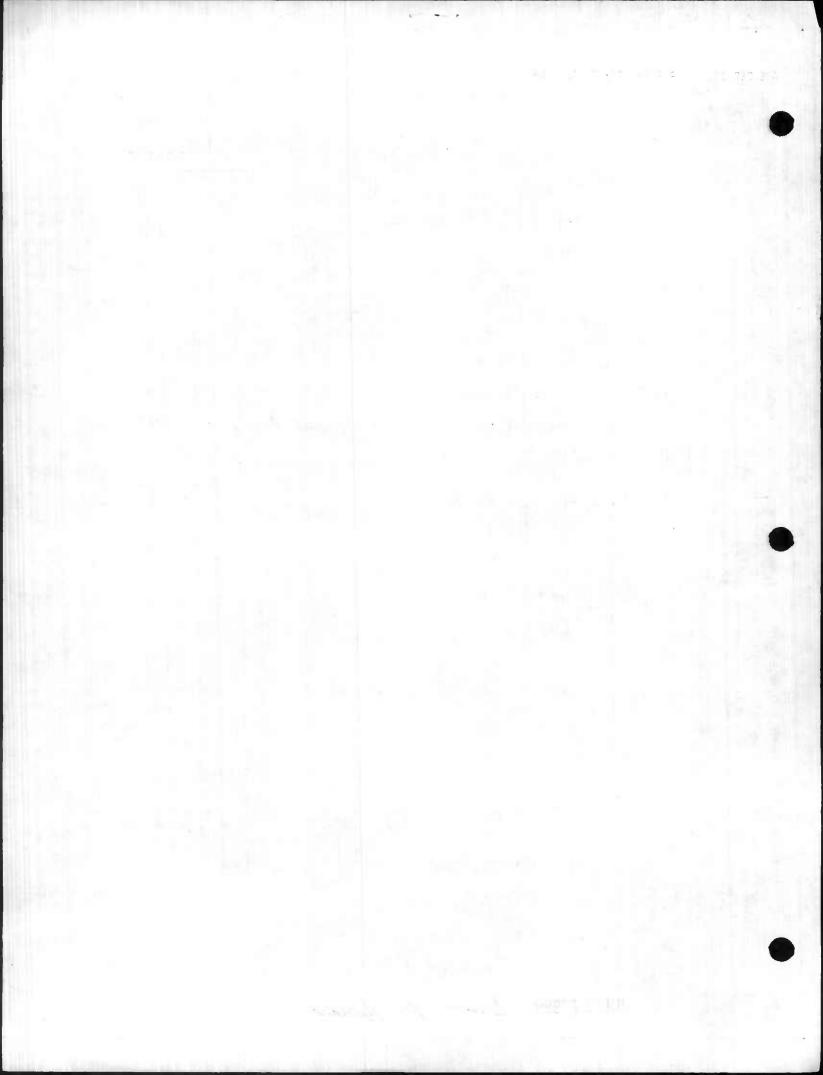


218325762 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death AMENDED ITEM #8 PER EH G773 7/27/99 AH 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death PATTERSON Month RUTH **Physician** 4:30 PM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner . NIA moni 05 X 069 00D If Under 24 Hrs. 8. Dete of Birth 2/28/19 79. Birtholece (State or Foreign Hours | Min. (Month, Dey. 26er) 79. 7. Age (In yrs. last birthdey) | If Under 1 Year | Months | Days 5. Sociei Security Number 6. Sex **Funeral** Days 1 M 2 F 92 218.32.5762 Director MD Usual Residence of Deceden the Manyland 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location ahow 7 is marked other than "natural", or itema 23s or 28s-f sho treumstic event, the Medical Examiner must be notified at Yes 2 No BALTIMORE Director NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 47 NO 1016 STREET Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian 11. Meritel Stetus permit. Pages 1 and 2 ahould be filed within 72 hours after to Department of Health and Mental Hygiene. Introchant: If flem 27 is marked other than "natural", or flest enyl injury or other treumatic aware. Bieck, White, etc. 1 Yes 2 No 1 Never Merried 2 Married 1 ☐ Yes 2 Z No Specify: Baltimore, Maryland 21215-0020 Specify: BLACK p 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) DOMESTIC HOME 12 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 8 VIRGINATE NELSON JACOB HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL KIDD BALTO. MO. 21215 DAUGHTER KOSECREST bate 20b. Place of Disposition (Name of cemetery, crematory or other place). 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ARBUTUS MEMORIAL PARK 7.28 99 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Fecility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signeture of Funeral Service Dicensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heer tailure) List only one cause on each line. BALTO. Approximata interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): ician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): physician sthe burial Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yaa 2 ☐ No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy 2000 1 Yes 2 000 1 Yes 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) To Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Mnpatient 28a. Delie of injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28c. Injury at Work? After 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, ferm, street, tactory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and menner as stated.

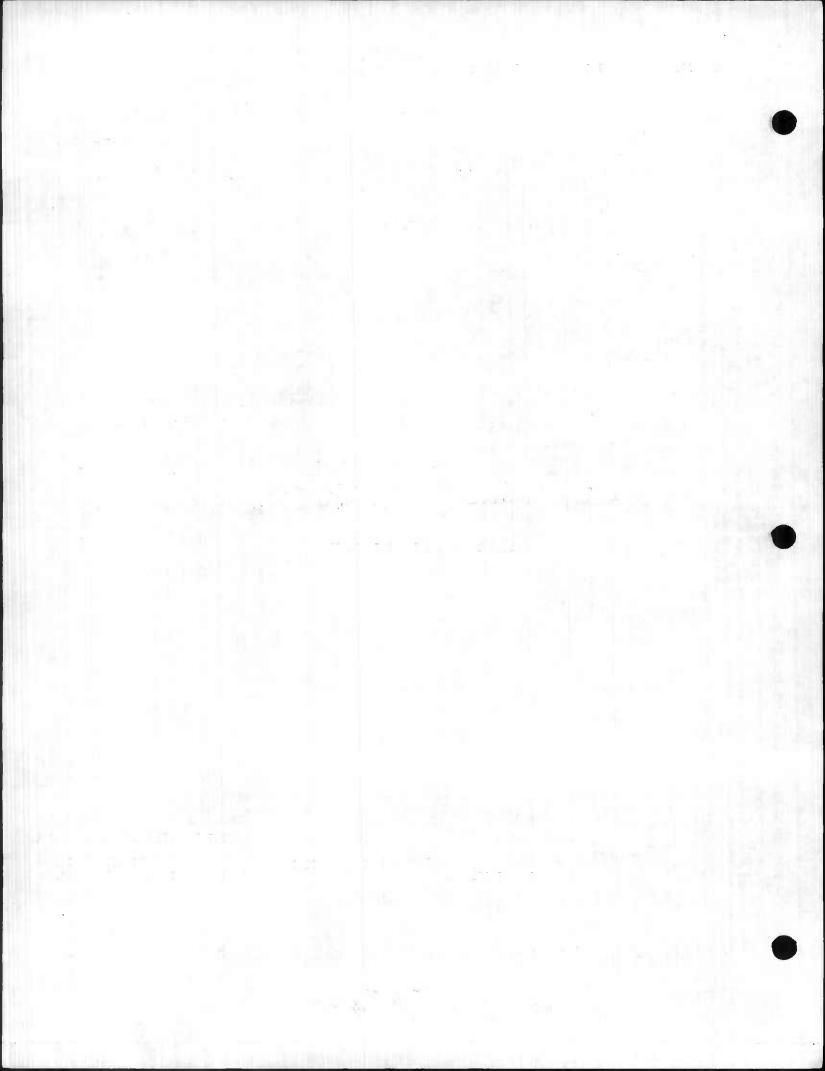
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Yder) 29b. Signeture and title of certifier 29c. License number D 30661 Durenem 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SIREESH TRIPURANEN) Rocen Blod, Baltinore 5hol Loch Hol 31. Date filed (MgULDay2*7)1999 32. Megistrar's Signatura State

DHMH 16 Rav 6/95

Registrar



OME E. INSON AMEND	ITEMS: #23 PART I, 27,	State of Maryla	nd/Depa	rtment of	Health and I	Mental Hy		23639
TITLEND	1. Decedent's Neme (First, Middle, Last		73 061	invate of	Dealli	2. Date of De	Reg. No.	3. Time of Death
Physician	Jerome	E.	Robins	on	Cva	JULY 2	23, 1999	1:23 PM.
/Medical Examiner	4e Facility Name (If not institution, give		KODIIIS		Sr. 4b. City, Town, or t			
	8411 KELSO DR.				ESSEX		Balt	imore Co.
Funeral	Social Security Number 6. Se	7. Age (In yr:	s. last birthday)	If Under 1 Year Months Days		8. Date of Bi (Month, D		Birthplece (State or Foreign Country)
Director	214-84-2687	38	Yrs.			1	0 61	M.D.
netural; or items 23s or 28s4 show deal Exercises must be notified at steed by Funeral Director	Usual Residence of Decedent 10a. Stete 10b. County	10c. C	City, Town or Loc	cation				10d. Inside City Limits
"natural", or items 23a or 28a-f show idnal Examinar must be notified at leted by Funeral Director	MD Cecil C			17.				1 ☐ Yas XIXNo
be notified Director	MD Cecil C	.O. P	erryvi	10f. Zip Code			10g. Citizen of	Whet Country?
a ie	634 Cole Stree	+		210	003		U.S	. A .
Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. V	/as Decedent of Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 14. Rac	ce - American Indian, ck, White, etc.
by FL	1 Never Married 2 Merried	1 ☑ Yes 2 ☐ No If Yes, Give		□ Yes 2CMio			Specif	
D D	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	16e Deced	ent's Usual Occu	mation		16h Kind of B	Black usiness/industry
piet	(Specify only highest grad	de completed)	(Give I	aind of work done NOT use retin	during most of wor	king	100. Kind of B	usiness/industry
mo:	Elementery/Secondary (0-12) 12th grade	College (1-4or 5+) Na	Fork	Lift (perator		MD Cu	p Company
Be Completed	17. Father's Neme (First, Middle, Last)				18. Mother's Nan	ne (First, Middle	e, Maiden Suman	ne)
To	Alexander Robin	son			Mary E	. Town	es	
	19a. Informant's Name/Relationship (T)				t and Number or Ru	iral Route Numb	ber, City or Town,	
	Alexander Robin 20a. Method of Disposition	son II-Fat	Par 25	27 Ceci	l Ave,	Baltin	ore Md	21218 City or Town, Stete
	1X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cometery, crem	atory or ourset pu	ace/			
	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	الما	arirson	Name and Addr	t Vet	7/29/9	9 Owin	gs Mills, Md
			N 14.	and D	/ TT T.7 = - 1-			
	23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused the de	ath. Do not ente	300 Walt	ash Ave	Palt	imore	Md 21215
an	shock, or heart failure. List only o	ne cause on each line.			West Health Land			Intervel Between Onset and Death
cal	Immediate Cause (Finel disease or condition	ALCOHOL AND	COCAINE I	NTOXICATI	ON			
er	resulting In death)	aDue to	(or as a consequ	uence of):				
ine.		b	٠	-				
Xar	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or as a consequ	uence of):				
cai Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events	C						
75	resulting in death) Last	Due to ((or as a consequ	rence of):				
2		d						
SICIS	Part II. Other significant conditions con	ntributing to death but not re	sulting in the un	derlying cause g	iven in Part I.	23b. Did	tobacco usa co	ntributa to the cause of death?
Physician/Mex						10	Yas 2□ No	3 Probably 4 DUnknow
by								
Completed						24e. Wes	s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause
Ē								of death?
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0	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2[☐ ER/Outpatient	2 DOA 0	26. Place of Dea			AT
n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inje	4LI NUISING N		how Injury occur	CAPACIO ICA
atio	1 Netural 5 Pending 2 Accident investigation	UNKNOWN	UNKNOWN		Yes 2 No	SUBJECT	INGESTED A	ALCOHOL & COCAINE
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home darmostre	BESIDE A	BUILDING/	28f. Location City or To	(Street and Number, State) 84	PAT OKEUTE' BOUSE NUMBER.
		INDUSTRIAL ARE	Á		- 37-132110/	ESSEX,	BALTIMORE	COUNTY, MARYLAND
Medical Certification: To Be Com	(Check only 2 Medical Exami	sician: To the best of my kn Iner: On the basis of examin						
Med	one)	and manner stated.			ise number			ed (Month, Day, Year)
	29b. Signature and title of certifier				C.M.E.		JULY 24,	
	The state of the s	X~						
	30. Name and address of person who co	objected cause of death (Ite			, Baltimo	re. Mar	vland 21	201
itate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature			_oy rack	, 2.	
egistrar	JUL 2719	999 Bener	N P.	Spor				



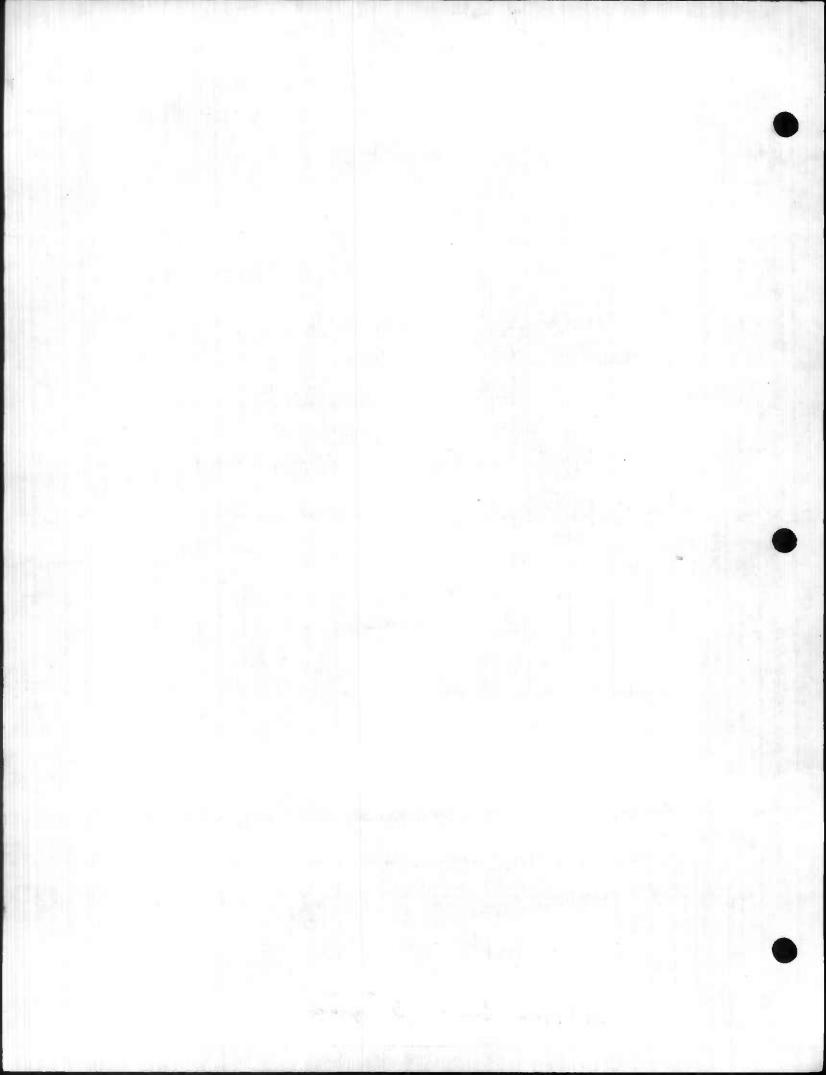
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death BANDALL NATHAN Month Day Year **Physician** 5.30pm 21 1999 JUL /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore or 5 delia Avenue If Under 24 Hrs. Birthplace (Stata or Foreign Country)
 A 8. Data of Birth Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Months 219-26-4980 12 M 2 F Hours Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits - how Baltimore 1 Yas 2 No NA Director d 280-1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 9 Cordelia 21215 Avenue SA Nema 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 □ Ves 2 □ No 14. Race - American Indien, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if frem 27 te marked other than "natural", or fren eny Injury or other traumatic event, tra Hedge. Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Black Specify: Specify: Completed by 3 Widowed 4 □ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry State of College (1-4or 5+) Elementery/Secondary (0212) Orrectional 2 th grade 171.24 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Kandal Illiam Wes -ly 11 Zabeth Jennings 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Woodlawn Nathe Randall 2002 Balto, Md Daughter 21207 20e. Method of Disposition
1 ☑ Burlal 2 ☐ Cremation 20b. Place of Disposition (Name of cematery crametory or other r Dete 20c. Location - City or Town, Steta or other place 3 ☐Removel Irom State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7-27-99 Anne Arundel Co, Ml 21. Signature of Fun val Service Licensee 22. Nama end Address of Facility 10alth, red Wabash Avenue 500 2 a Prif1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or helm fellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel INFARCTION MYOCARDIAL disaasa or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner HYPERTENSION The law requires that the deeth certificate be executed Sequentielly list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last Due to (or es a consequence of): HYPERCHOLESTEROLEMIA Physician/Medical Due to (or as a consequence of): USB P.0. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yaa 2□ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were autopsy lindings available prior to Completed 24a. Wes an autopsy completion of cause of death? page 2 2000 1 Yes 1 ☐ Yas 2 ☐ No certificate Hospital or Attending Physicien: 25. Was case referred to medical axaminar? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yas 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 5 Pending investigation 1 Netural efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, lerm, street, fectory, office building, etc. (Specify) 5 4 Homicide To the Hospital within 24 hours or To the Funeral Completely filled: 124Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) end manner stated. 29a. Certifier 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 050237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GLYNIS A MOODY, MD WAXTER CENTRE
1000 CATHER CATHEDRAL BALDMORE, MO 21201 ST 32. Registrar's Signature 31. Dete filed (Month, Day, Year)

Registrar DHMH 16 Ray 6/95

State

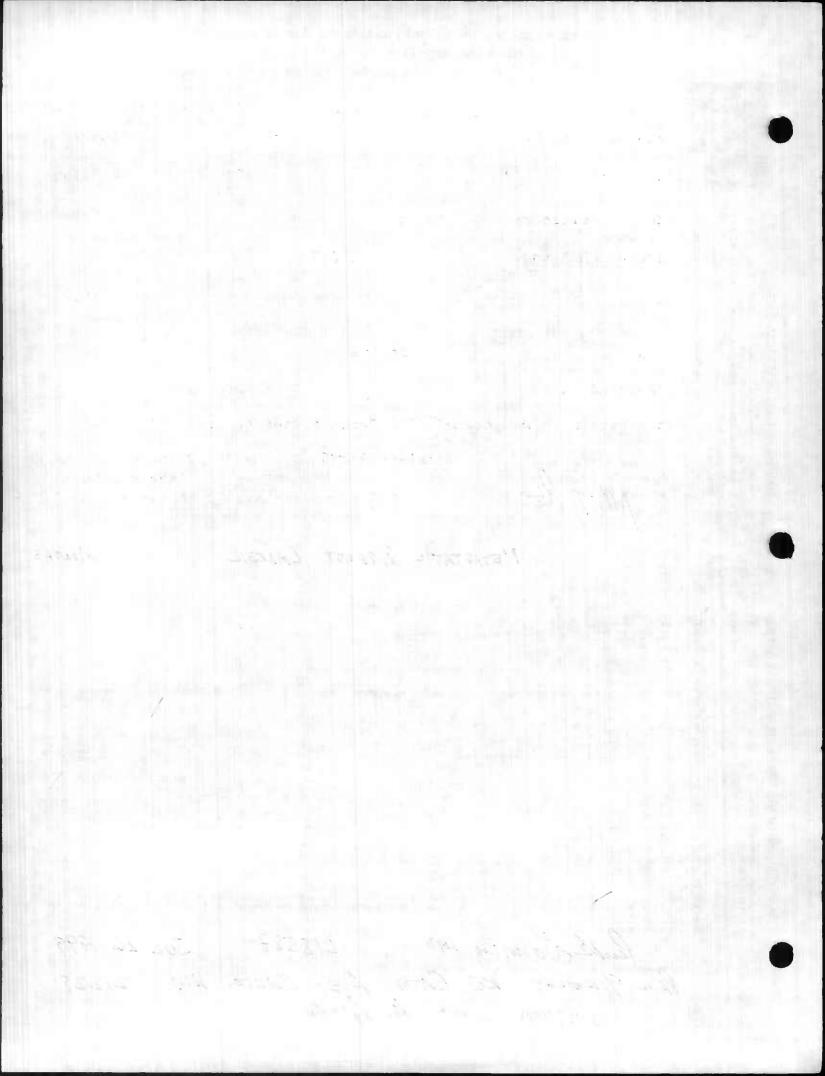


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Physicia	n Mary G	1. Decedent's Nama (First, Middla, Last) Mary S. Rose								2. Data of De Month	Day Year		3. Time of Death	
/Medica Examine	4a Facility Name	(If not institution, give		er)			4			Cation of Death	22, 1999 13 4c. County of Death		11:00A.M.	
Funeral Director	5. Social Security			Aga (In yrs. 93	last birthday, Yrs.	If Under Months	BALTIMOR 1 Yaer ff Under 24 Hrs. Days Hours Min.		LMORE 24 Hrs. Min.	8. Data of Birl Sept.	y. Year 905	9. Birthplaca Country) MINNES		
2	Usual Rasidence													
show	10a. Steta	10b. County		10c. Cit	y, Town or L							10	Od. Inside City Limits 1 ☐ Yes 2 → No	
the Ma	MD MD	Balti	more		Caton	sville							1 Yes 2LINO	
death with the Maryland ma 23a or 28a-f show mant be notified at	MD 10e. Street and No. 715 Ma		ice Lane PV 415				1228	3			10g. Citizen of U.	What Count S.A.	iry?	
3 2 3 3	3 [™] Widowed	11. Meritel Stetus 1 Nevar Married 2 Merried 1 Nevar Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decede Armed Force 1 Yas, 2 H Yas, Giva Year or Dete			,S. 13.	Was Deced It Yes, spec				ecity Yes or No Rican, atc.)	Bla	ce - America ack, White, a fy: Whit	itc.	
within one.	(Special Control of Co	15. Decedant'a Ed ecify only highest gra condery (0-12)		(Give	dent'a Usue kind of wor DO NOT us	k done d	durina mos	it of work	ing	16b. Kind of E		ustry		
and 2 has filed at other avent, it	17. Father's Name	a (First, Middla, Last)		Hiomei	lakei		18. Motha	ar'a Name	(First, Middle,			-		
ylan Wental Mental arked o	17. Father's Name	Swerdlof	f				Est	her	(unk)					
Marylan and 2 should be naith and Menta a 27 is marked or traumatic av	4	Name/Relationship (1						and Numbe	er or Run	d, Apt 3				
more 1-		sposition Cremation 3 5 Other (Specify		cemetery, crematory or other place)							Date 20c. Location - City or Town, State 24/99 Woodlawn, Maryland			
Baltimo	21. Signature of F	Funeral Service Licen	see Lem	ner					ty Wil	tzke Fu	neral H	omes,		
Physician	23a. Part1. Enter tha disaasa, or complications thet caused tha death. Do not enter the mode of dying, such ea cardiac or respi ahook, or heart feilure. List only one ceuse on each line.								or respiratory a	rrest,		Approximate Intarval Between Onset and Death		
/Medical Examiner	tmmediate Causa (Final disaeaa or condition resulting in deeth) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence ot):											1		
nsit ded	Sequentially list of if any, teading to it		b											
760, be executed stelan and burial-transit		conditions, immadiata darlying	Dua to (or as a consequanca ot):							1 1				
nificate ng phy	resulting in death)	its	d	Dua to (o	r es a consec	quence of):								
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P.O.	É	ifficant conditions or	ontributing to deati	n but not res	uiting In the u	indarlying ca	iusa giv	en in Part f	í. 		tobacco usa c Ysa 2□ No		the cause of death'	
Records,	Completed by									perfo	an autopsy	autopsy 24b. Wara autops available pric completion o		
The law ate has page 2				INSPECTION 1□ Yas 2♥ No									of death?	
	25. Was casa rate examinar?	-						26. Place	of Deat	h (Check only o	ona)			
- 2 g 5	Yes 2	□ No	Hoapital: 1 Inp		ER/Outpatie			4 LI NI	ursing Ho	me 5 Rasi	dence 8 🗆 O	har (Specify)	
Vision of Attending Phart the Control of the funeral by the funeral	27. Manner of Des 1) Natural 2 Accident	5 Pending investigation		njury Day Year)	28b. Time of tnjury	M 2	Bc. tnjun Worl	y at k? Yas 2□		28d. Describe	how Injury occu	bern	1.76	
Division or Attending after deeth. Director: Afte	3 ☐ Suicide 4 ☐ Homicida	6 Could not be datarmined	28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)							281. Location (Street end Number or Rural Routa Number, City or Town, Stata)				

State
Registrar

DHMH 16 Rav 6/95

Margarita Korell, M.D.

31. Date tiled (Month, Day, Year), 1999

29b. Signature and title of certifier

29e. Cartifiar

32. Registrar's Signature

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(a) and manner as alated.

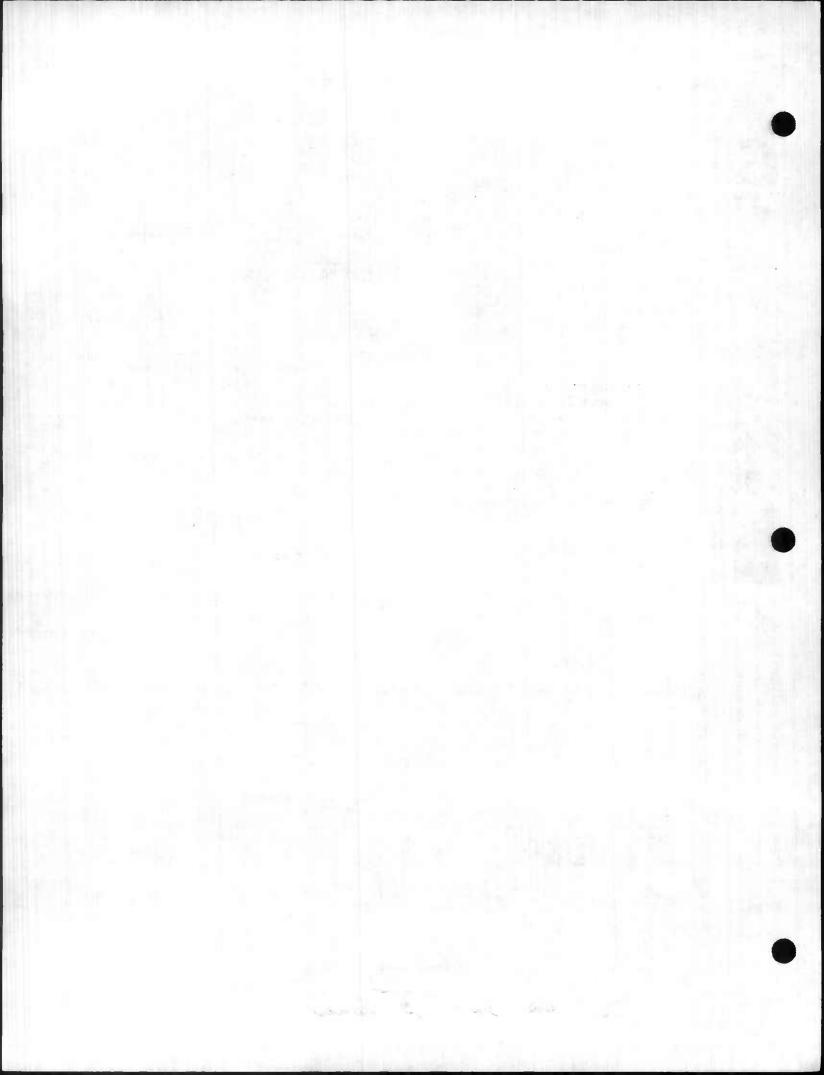
**Continuing Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner ateled.

29c. Licensa number

O.C.M.E.

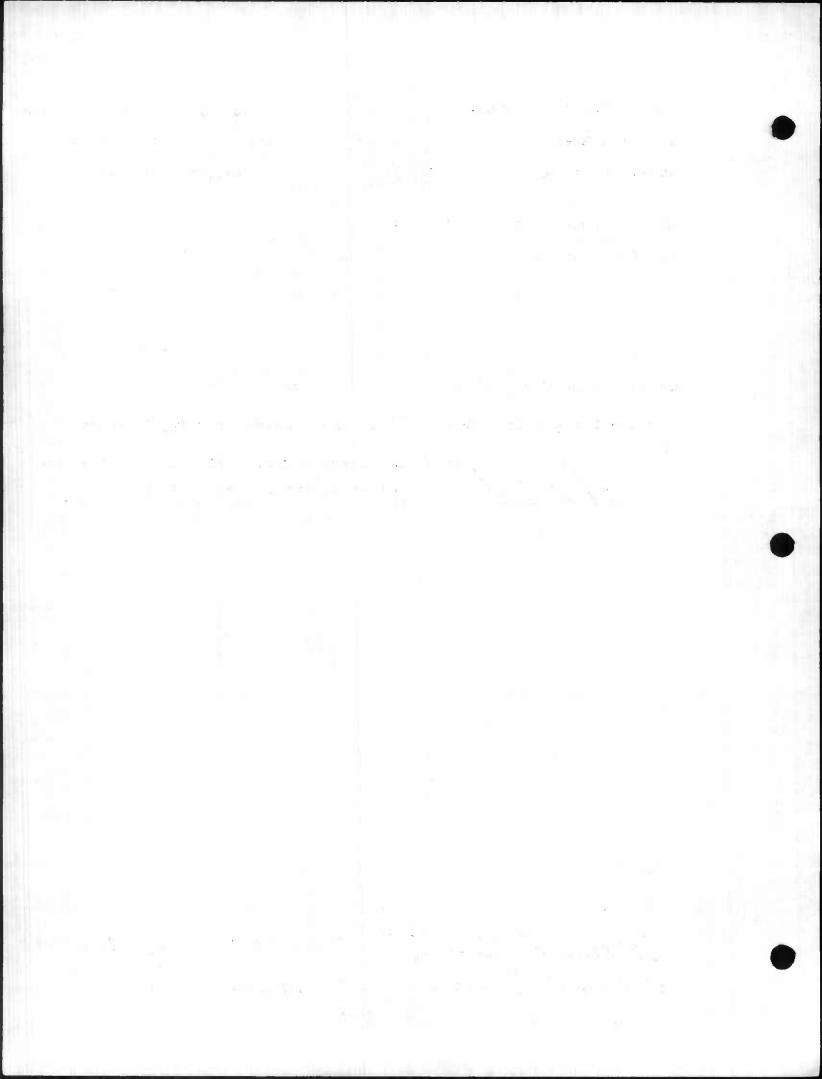
29d. Data signed (Month, Day, Year)

JULY 23,1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth Month. Dev Yeer

						Cert	ificate c	of Death		Reg. No.	22	40	04.0
	Physici	on	1. Decedent's Neme (First, Middle, Las	•					2. Dete of De Month,	eth Dey	,	Yeer	. Time of Death
	/Medi		Donald Francis						July	21		999	1730
	Examir		4a. Fecility Neme (If not Institution, give 494 Lisa Avenu	The contract of the contract o				4b. City, Town, o	Location of Deet		County o	Aruno	del
	Funeral Director		000 0-01 1		last b		If Under 1 Ye Months De			th Year)	920	9. Birthplece Country) Kansa	e (Stete or Foreign a.S
П	pue *		Usuel Residence of Decedent 10e. Stete 10b. County	10c. C	ity, Tov	vn or Loca	tion					10d.	Inside City Limits
	Maryi 4 sho	jo	MD Anne A	rundel Od	lon	ton							1□Yes 2□No
	T28e	Irec	10e. Street and Number	Tunder od	CII	COII	10f. Zip Cod	6		10g. Citiz	zen of W	het Country?	
	h with	al D	494 Lisa Avenu	e			21	113		USA	A		
020	a within 72 hours effer death with the Maryland jiene. I than "naturet", or items 23s or 28s-f show the Medical Evariner must be notified at	by Funeral Director	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:	J,S.		es Decedent d'es, specity C	of Hispanic Origin? (uben, Mexican, Pue No Specify:	Specify Yes or Norto Rican, etc.)	1		- American i , White, etc. Whit	
5-0	72 ho	sted	15. Decedent's Edu (Specify only highest grad	ucation	166	Deceder	nt's Usuel Oc	cupetion ne during most of w	orkina	16b. Kir	nd of Bus	iness/indust	ry
121	ighin and in	Completed	Eiementary/Secondary (0-12)	Coilege (1-4or 5+)		life. DC	NOT use rel	tired)	orning .			7	
2	77 75 24 66	S	17. Fether's Neme (First, Middle, Last)		5	gt.	Major					Army	<u>Y</u>
Maryland 21215-0020	12 should be filed h and Mental Hygi 7 is marked other traumatic sysht, i	To Be	Charles Edward	Reynolds					Mohler		Sumame	9)	
Mar	and la ma	100	19a. Informant's Name/Relationship (T)			_		eet and Number or F					*
	of Health of Health if Itsm 27 I		Stephen C.Reyn					ord Rd.					
Baltimore,	Peges nent of H int: If its any or of		20a. Method of Disposition	HOITIUVALITUTII GLALO			ion (Neme of tory or other) Veter	plece)	7/26			City or Town,	e, MD
Balt	permit. Peges Department of Important: If It any Injury or once.	, //	21. Signeture of Funeral Service Licens	100/1/1	_	Ha	rdest	dress of Fecility Ly Funer		-			
	_		23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only o	lications thet caused the dee	th. Do	not enter	Ridge the mode of	ely Ave.	Annapo	lis,	, MD	21	401 proximate erval Between
	Physician /Medical Examiner	er	Immediate Cause (Finel disease or condition resulting in death)	· Arter	10		erot	-ic /-1.			sea	On	iset and Deeth
	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leeding to immediate	b. — Due to (or as a	conseque	ence of):						
68760,	sician b buria	calE	cause. Enter Underlying Cause (Diseese or Injury that initiated events	C									
×	5 50	/Medical	resulting in death) Last	d	or es e	conseque	nce or):					1	
Bo	or it	clan							1				
P.O.	the d y the ached	Physician/	Part II. Other significant conditions co	ntributing to death but not res	sulting	In the und	erlying cause	given in Pert I.		Yes 2	_	tribute to the 3 Probebl	e causa of death? ly 4 death?
	es tha gned be de	by F											70
Vital Records,	been s	Completed							24e. Wes	an autop ormed?	ssy	avsllet	autopsy findings ble prior to etion of cause th?
Ä	0 - 0	mo:							10	Yes 20	JUNO .	1⊡Ye	95 Z No
ita	ician: Th	Be	25. Was case referred to medical examiner?					26. Place of De	eath (Check only	one)			
of V	0 0	10	1 N Yes 2 No		ER/O	utpatient	3□ DOA	Other: 4 Nursing	Home 5 1 esi	dence 6	B □Other	r (Specify)	
ion	After	ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		Time of Injury		njuryat Work? I∐Yes 2∏No	28d. Describe	how injury	y occurre	d	
Division	교육등	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At h building, etc. (Spech	ome, f	erm, stree	t, fectory, offi	ce	28f. Location (City or To			r or Rural Ro	oute Number,
	ne Hospital n 24 hours ne Funeral pletely filled	edicai	29a Certifier (Check only one) 1 Certifying Pray 2 Medical Exami	iner: On the basis of examina and manner stated.	wiedg ation ar	e, death o nd/or inves	ecurred at the stigation, in m	time, date and place by opinion, death occ	e, and due to the curred at the time,	date and	and man place, ar	nor as statu nd due to the	d. cause(s)
	To the within 2 To the comple	×	29b. Signature and title of certifier	no De	206	cty		ense number	0.1			(Month, Dey	, Year)
			Millian	st do	m	o '	L	060	74	-	7/2	1/9	9
			30. Name and eddress of person who co	omplet duse of death (iter	m 23a)	(Type, Pr	int)	5 Am			1		
			William P	· Jones,	ho	D	69	5 Am	erici	4	21	039	5
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registrer's Signa	eture	4.	Low	las					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend Item 7, 8, per F.H., G773, 7/27/99, gap 1. Decedent's Name (First, Middla, Last)-2. Deta of Daeth **Physician** an 1999 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Nama (If not institution, giva street and number) Examiner Lorien Riverside Nursing Home Belcamp 8. Deta of Birth 04/26/21 9. Birthplece (Stete or Foreign Allg 127, 1997) 11 Martin and 7. Age (In yrs. last birthday) | If Under 1 Yeer If Under 24 Hrs. 5. Sociei Security Number 6. Sex **Funeral** Hours 1 M 2 □ F Months Days 77 78 Yrs. 216-18-9912 Director Usual Rasidance of Dacadani the Marylend 10a State 10b. County 10c. City. Town or Location 10d. tnsida Cltv Limits flams 23s or 28s-f show 1 Yas 2 No MD. Harford Bel Air Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 U.S.A. 205 L. Burkwood Court death Funeral 12. Waa Decedant Evar in U,S. Agned Forcas? 1 M Yes 2 □ No tf Yes, Giva Year or Datas: 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yea or No-It Yes, specify Cuban, Maxican, Puarto Rican, atc.) 7 is marked other than "natural", or item traumatic event, tre Mexical Examiner Black, White, atc. 1 Never Married 2 Married 1 Yas 2 No Specify: Baltimore, Maryland 21215-0020 Specify þ 3 ☐ Widowed 4 🕱 Divorced White Completed 16a. Decedent'a Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry tel Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) Truck Driver Trucking 9th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 12 should be fi h end Mentel H I a marked ott Virginia Lillian Proctor Frederick Schollian 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Raiationahip (Type, Print) Pages 1 end 2 s nent of Heelth en ant: If item 27 is r Bel Air, MD. Barbara Reichart (Daughter) 205 L. Burkwood Court. other 1 20b. Place of Disposition (Nema of cematary, cramatory or other pleca) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Department of Important: If it any Injury or c 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 7/26/99 Baltimore. Maryland Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Fecility 21. Signetura of Funaral Sarvica Licansaa Schimunek Funeral Home of Bel Air, Ian Burn a. Un eles 610 W. MacPhail Road. Bel Air, MD. 21014 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** SEPSIS /Medical Immediata Cause (Finel disease or condition rasulting in daath) Examiner Dua to (or as a consequanca of) Examiner buriel-transit Sequantieily list conditions, if any, leading to Immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avec or injury Dua to (or as a consequence of): Physician/Medical thet initieted events rasulting in daeth) Last the Due to (or es e consequence of): 65 esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco was contributs to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown CIRRHOSIS, LAGINEC'S þ 24b. Were autopsy findings available prior to compiation of cause of death? DEMONTIA, MULTINFARCT 24a. Was an autopsy Completed 240 No 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital funerel director 25. Waa casa rafarred to medical Be 26. Place of Daath (Check only one) Othar: 4 Norsing Homa 5 Residence 8 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Deta of Injury (Month, Day Year) Certification: 27. Mannar ot Deeth 28b. Tima of 28c. tnjury et Work? 28d. Dascribe how Injury occurred 1 Ad Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant efter death Director: 6 Could not be datarmined 28e. Place of Injury - At homa, farm, streat, fectory, office building, atc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide 9 24 hours Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifiar Medical (Check only one) To the Vithin 2 29d. Data signed (Month, Dey, Year) 29b. Signatura end titla of certifiar 29c. License number Hadra Nowahows mo 008096 30. Nema and address of person who completed cause of deeth (tam 23e) (Type, Print)

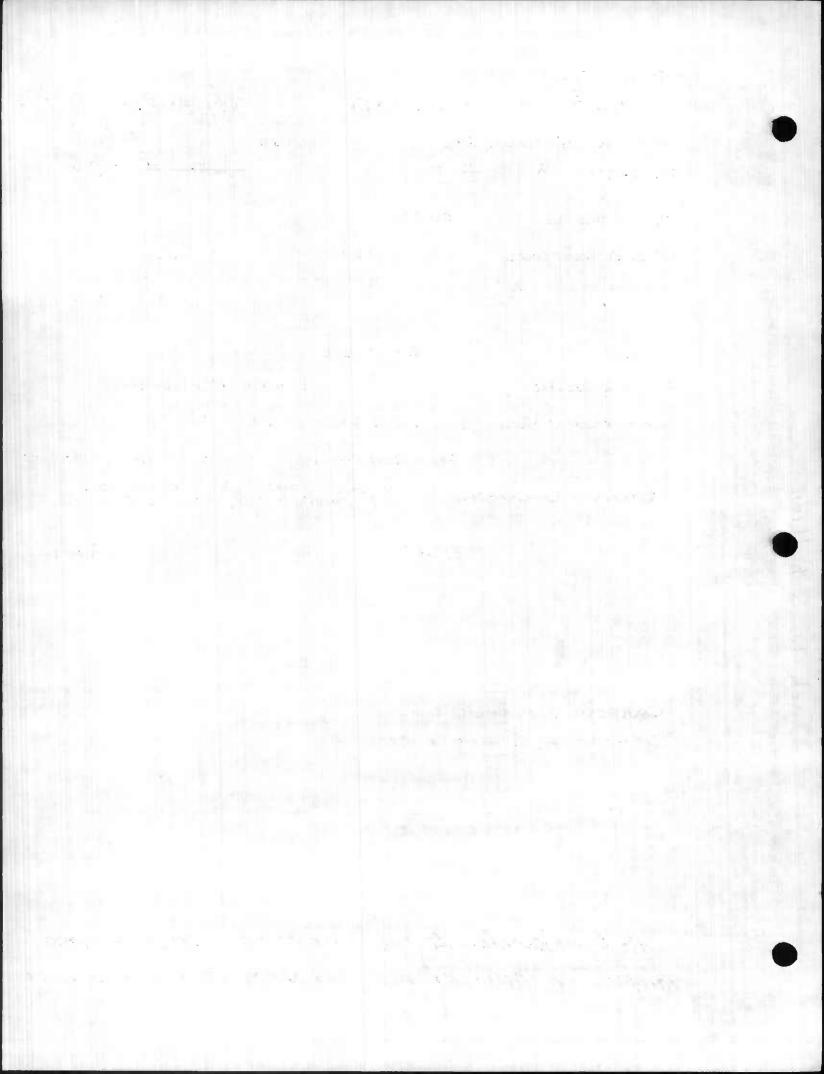
ANDREW NOWAKOWSKI WD 125 N. MAWN ST. BECALRUDZIOIY

State

31. Data tiled (Month, Day, Yaar)

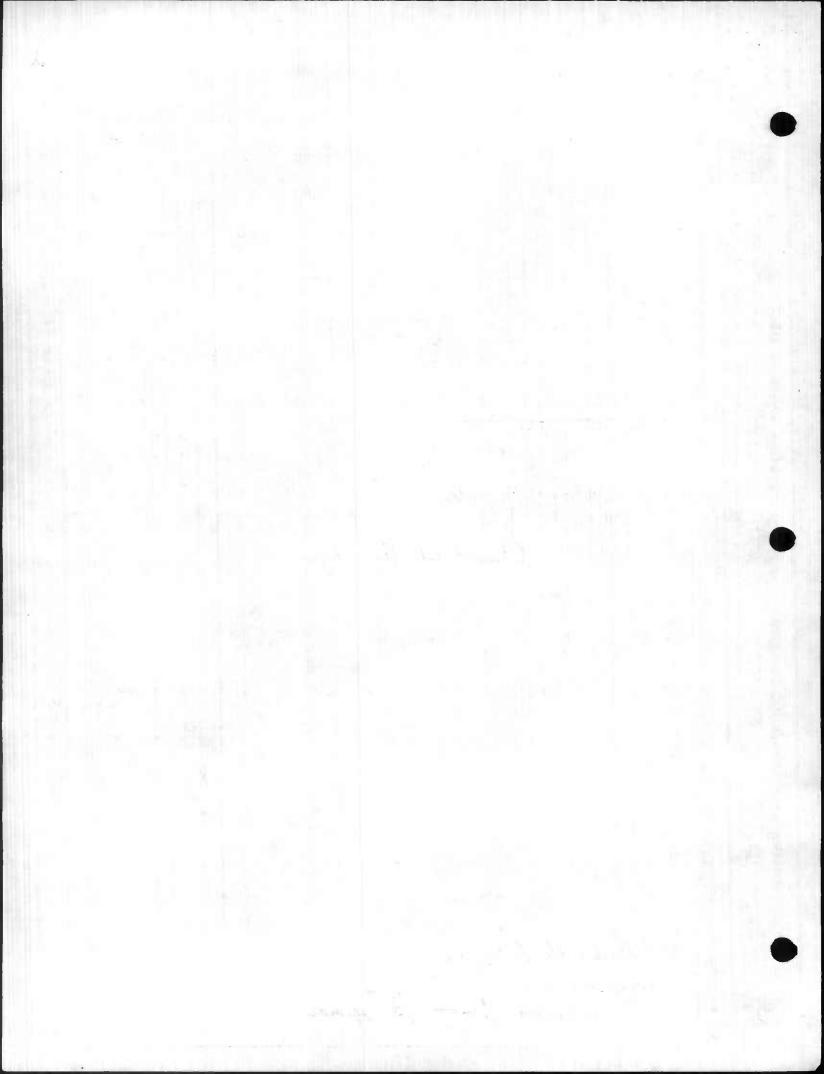
32. Registrer's Signatura

2 7 1999 Registrar **DHMH 16 Rsv 6/95**



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IARD ICKER MEND: #19A PE	R MEO G774 8-6-99 WR.	State of Ma	ryland / Depa	artment of F rtificate of			gieneg 9	23	3645
Physician /Medical		ichard Geor	ge Schucke			2. Dete of De Month JULY	20, Dey 1999		3. Time of Death 6:15 PM.
Examiner	4e Facility Name (If not institution, g. 3736 OAK AVE.	ve street and number)			4b. City, Town, or I Baltin			of Death)C
Funeral Director	Sociel Security Number 6.	Sex 7. Age	(In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Deys			th ay, Year)	9. Birthple Count	ace (State or Foreign
pu Pu	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10	d. Inside City Limits
Maryl Maryl Tor	MD Bal	timore	Balti	more					1 ☐ Yas 2 ◯ No
or 28a	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Count	ry?
ath w	3736 Oak Aven	T-		212			USA		
within 72 hours after death with the Maryland ane. Then "retural", or heme 23e or 28e-f show the Medical Exercitor must be notified at the property of the pro	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X X If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Ispanic Origin? (Sen, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specify	ck, White, e	
ted it	15. Decedent's I	Education	16a. Dece	dent's Usual Occup	pation	tina	16b. Kind of B	usiness/Indi	ustry
and the Header of the Header o	(Specify only highest g	College (1-4or 5	+)	kind of work done DO NOT use retire			Compute		
d other than evant, the Be Be Comp	17. Father's Name (First, Middle, Las	Z t)	Seni	or Soli	d State				uring
To Be	, , ,	" ayne Schu	cker		}	enna R		7	
T T	19a. Informant's Name/Relationship	(Type, Print)	19b. Meili	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Town,	State, Zip	Code) APT.400
77 I	GLENNA L. SCHOCKERY	OTHER mothe		N. Rid	ge Rd.	Ellico			
or other	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State		natory or other pla		Date	20c. Location -		
dan's	4 Donation 5 Other (Spec	ity)		ematory,			Balti		
Important: If any injury or 2002.	21. Signature of Funeral Service Lice	Menon	ald "	Cremati 299 Fre	ön Söci derick	ety of Rd. Ba	Maryla Itimore	and, e, MI	Inc. 21228
shysician and the burla-transit the burla-transit calcal Examiner	tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Due to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a)	quence of):					
e attending physician and address of for use as the butal-transisiscian. Address of the butal-transisician with address of the physician and the address of	resulting in death) Last	d	Due to (or es e consec	luence of):					
ed by the atterded for detached for	Part II. Other eignificant conditions	contributing to death bu	t not resulting in the u	nderlying cause gi	ven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?
y Ph						10	Yea 2□ No	3 Prob	ebly 4 Unknown
cate has been signed by the attending p , page 2 should be detached for usa as Completed by Physician/Mer							en eutopsy ormed?	CON	re autopsy findings illable prior to appletion of cause leath?
page 2						100	Yes 2□No	1/2	Yes 2□ No
B School	25. Was casa referred to medical examiner?				26. Place of Dec	oth (Check only	one)	1	
this of the said direction of the said direc	1 💢 Yes 2 □ No 27. Menner of Death	Hospitel: 1 Inpetie		IL SEL DON			idence 6 Oth)
To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	1 Natural 5 Pending investigeti investigeti 3 Suicide 6 Could not determine	(Month, Day	Year) Injury	M 1	rk? Yes 2□No		Street and Numi		Route Number,
od in b	4 Homicide	building, efc	. (Specify)			City or To	wn, State)		
To the Funeral completely filled Medical C		hyeician: To the best o miner: On the besis of and manner sta	examination and/or in						
To the Funeral completely fille Medical C	29b. Signeture and title of certifier	1 1.		29c. Licens			29d. Date signe		
	7 Meadre l	1. King	Lys.		O.C.M.E.		JULY 21	, 199	9
	30. Name and eddress of person who	King	111 Per	Print) nn Street	, Baltim	ore, Mai	ryland 2	1201	
State Registrar	31. Date filed (Month_Day, Year) JUL 27	1999 32. Registra	r's Signature	. Sport	les				



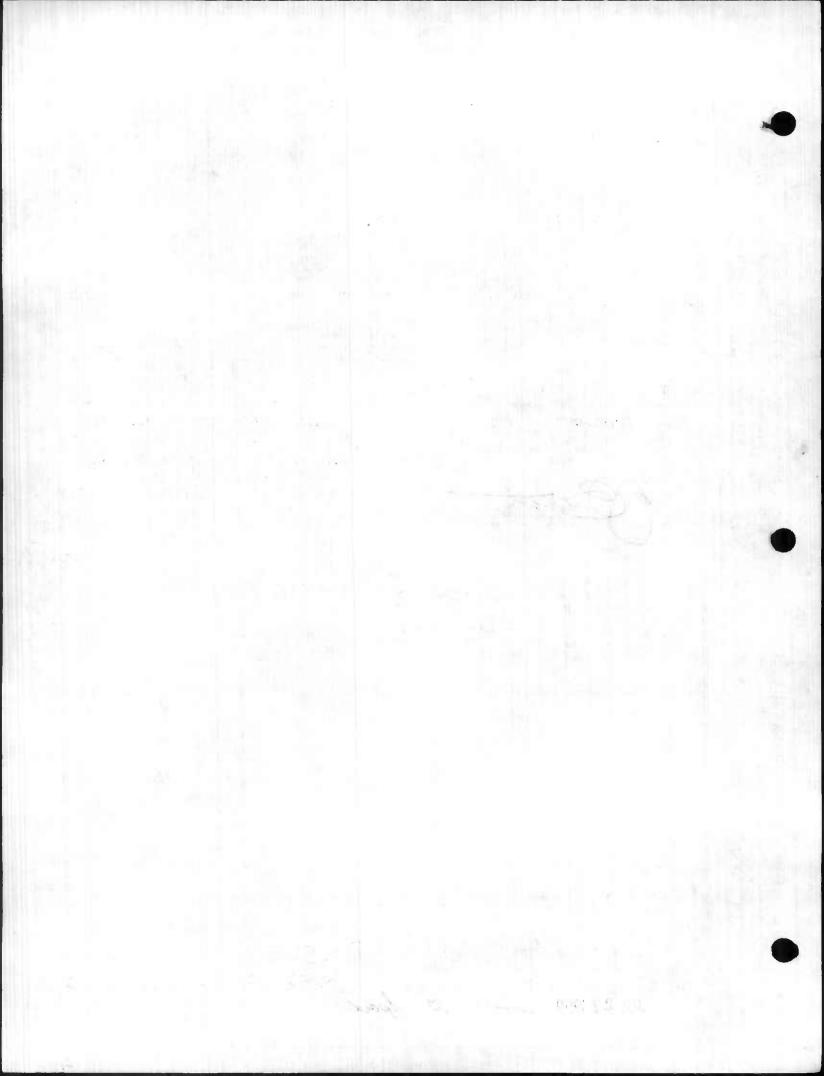
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State of Maryland / Department of Health and Mental Hygiene 99 23646

				Cei	rtifica	te of l	Death			Reg. No.			
inia	1. Decedent's Name (First, Midd	lle, Last)							2. Dete of Month	Death Day	Yea		ima of Death
sician edical	CARRIE	STRIC	KLINE		S	CHME	ISSER		JULY	24,	1999	1 1 .	15 PM
iner	4a Facility Nama (If not institution 1605 RUSKIN R	on, give street and n OAD	umber)			-	b. City, To		ecation of De	ath 4c. C	ounty of De	eeth E ARUN	IDEL
ıl r	5. Social Security Number 215-09-6297	6. Sex 1 ☐ M 2(C) (F		3 Yrs.	If Unde Months	or 1 Year Deys	If Under Hours	24 Hrs. Min.	8. Deta of (Month, MAY	Birth Day, Year) 4, 190	9. B	Birthplaca (S Country) ARYLA	State or Foreign
	Usual Residence of Decedent							-					
ctor	MARYLAND ANNE	ARUNDEL	10c. C	ity, Town or Lo GLEN		NIE							ide City Limits Yes 2 No
il Director	10e. Street end Number 1605 RUSKIN ROA	VD			101. Z	ip Code	21061	L			on of What		
by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorce	Armed F	200No Give		Wes Deci		ispanic Ori n, Mexicar Specify:		ecify Yes or Rican, etc.)		. Race - Ar Black, WI pecify:	merican Ind hite, etc. WHI!	
Completed I	15. Deceder (Specify only higher	nt's Education ast grade completed	0	16a. Deced	ient's Usi kind of w	ual Occupi ork done o use retired	ation during mos	it of work	ing	16b. Kind	of Busines	ss/industry	
mo.	Elementery/Secondery (0-12)	College	(1-4or 5+)			CANN				CAN	NING	INDUS'	TRY
o Re C	17. Fether's Neme (First, Middle, JOHN	Last)	STRICK	KLINE			18. Mothe KATE			fle, Maiden Si (Shri)	
	19a. Informant's Name/Relations ROBERT SCHMEISS		SON)	1						URNIE,			
	20a. Method of Disposition XXBurial 2 Cremation 4 Donation 5 Other (5		n State	Place of Dispo cometery, crer	natory or	other plac			7/27/9	9	IDGE,	or Town, St	ate
	21. Signature of Funeral Service			22	. Name a	ind Addres	s of Facili	y SI	NGLETO	ON FUNE	CRAL H	HOME,	
/Medical Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last	6	Mahr	er und for es a consequence or es a consequence or es a consequence	quence of):	as	<u> </u>	Den	rente	a.	71	renth
Physician	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying	cause give	en in Pert	1.	23b. D	fd tobacco us	se contribu	ute to the c	ause of death?
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State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** VERNON MOYER SCHLUTTER July 24,1999 12:10 PM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Baltimore County Manor Care Nursing Center, Ruxton Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 15 M 2□ F Months Director 215-03-8592 Aug 14, 1912 Maryland Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23s or 28s-f above the Medical Examiner must be notified as 1 ☐ Yes 2 No Director Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 USA #1106 Funeral Smeton Place, Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Evar in U,S. Armed Forces? 11. Meritel Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after ment of Health and Mental Hypiene.
Artic If hem 27 is marked other than "natural", or the ury or other traumate avent, the Medical Essentian ury or other traumate avent, the Medical Essentian. 1 ⊠ Yas 2 □ No If Yes, Giva 1 Nevar Married 2 Merried WWII 21215-0020 1 Yes 2 No Specify: White Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 12th Realtor Baitimore, Maryland 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be John Leopold Schlutter Anna Marie McWilliams 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) (Wife) Mrs. Mary Catherine Schlutter Smeton Place, #1106 , Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or buce. 7/26/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory of Funeral Service Ligans 22. Nama and Address of Facility larten C Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Takson Martin D. Transon

23a. Part 1. Enter the diseasa, or complications that caused the death. Do not enter the most orwing, such esical plac or respire on area.

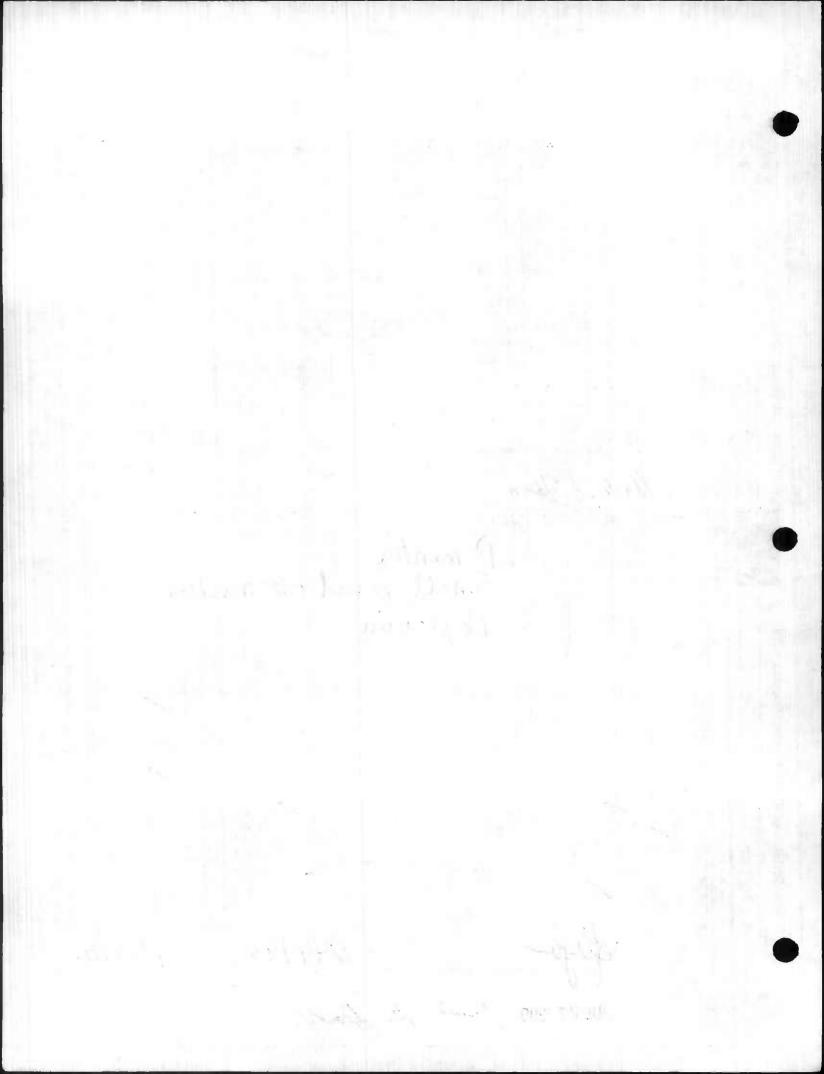
Approximate Intervel Between Onset and Deeth. **Physician** /Medical tmmediete Ceuse (Final diseasa or condition resulting In deeth) Examiner obstructuri Examiner owe ician and burial-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last physician s the burial Box 68760, renum Physician/Medical 88 for use P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed t Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai or Attanding Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 1 Netural 5 Pending 1 ☐ Yas 2 ☐ No death. investigetion 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stefa) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital edical 29a. Certifier 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) within 2. \$ 29d. Date signed (Month, Day, Year) 29b. Signature and titla of atifier 29c. License number 30. Nema and address of person who completed cause of deeth (item 23a) (Type, Print) 7600 Osler Drive, Towson, Maryland 21204 VM. N., Sanai, 32. Registrar's Signature 31. Dete filed (Month, Dey, Year)

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2º2no Month 8 : DU pm VIRGINIA SMITH 16,019 uh 4a Facility Name (If not Institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death W&S7 minster _arrill If Under 1 Year Conno If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days Months Hours 10 M 20 F 212-09-3200 80 10-07-1918 MARYLAND Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND CARROLL WESMINSTER 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1104 BARSTON DRIVE 21157 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 YEARS N/A TELEPHONE OPERATOR C & P TELEPHONE 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) HARRY DUNPHY LAURA WEATHERSTINE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL A. CARTER (DAUGHTER) 1104 BARSTON DRIVE WESTMINSTER, MARYLAND 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-26-99 BALTIMORE, MARYLAND NEW CATHEDRAL CEMETERY 21. Sign store of Functional Service Licensee 22 Name and Address of Facili LORING BYERS FUNERAL DIRECTORS, INC. J. WAYNE OSTERLING 8728 LIBERTY ROAD RANDALLSTOWN, MD o, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. b. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediete Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 (No 1 TYes 215 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

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Physician

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pamit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or iten any injury or other traumatic event, the Hedgel Examina-

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Certification: To

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29a. Certifier (Check only one)

21215-0020

Baltimore, Maryland

the Medical Examiner must be notified at

Director

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Completed

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1 Yes 25 No 27. Manner of Death

25. Was case referred to medical examiner?

2 Accident 3 Suicide 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 180Ai 20 memorial Ave, Wastminster, V

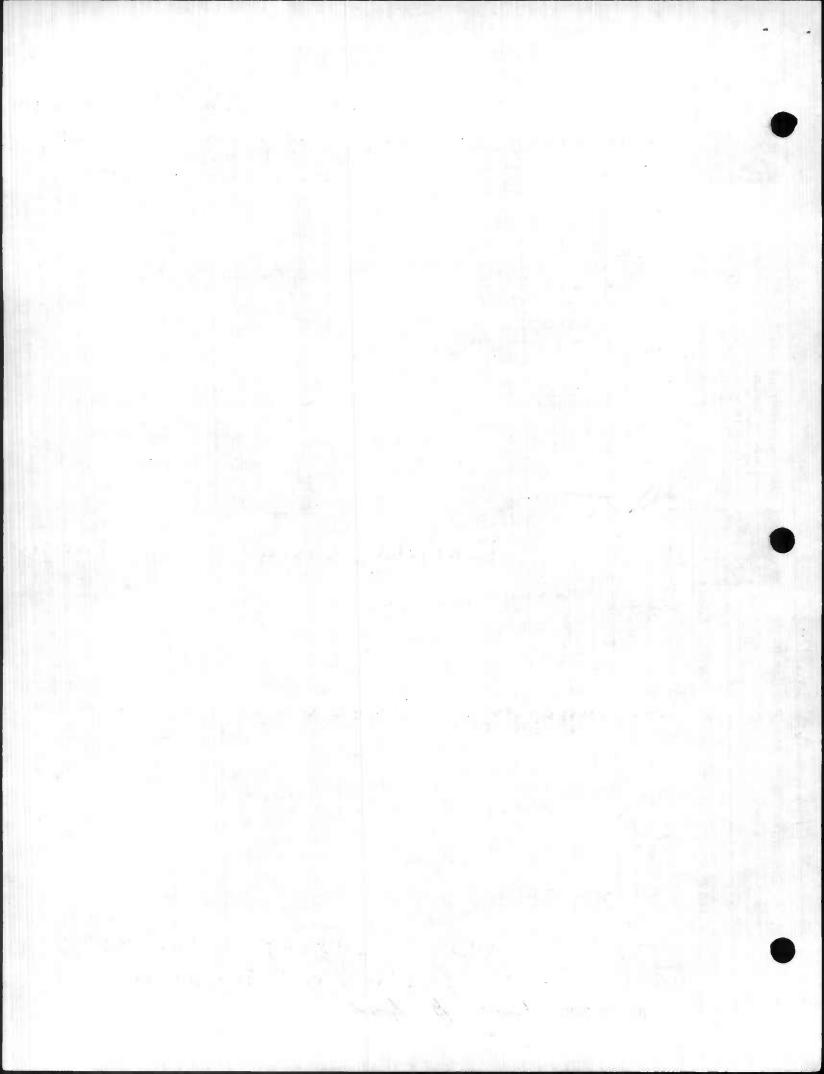
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State Registrar

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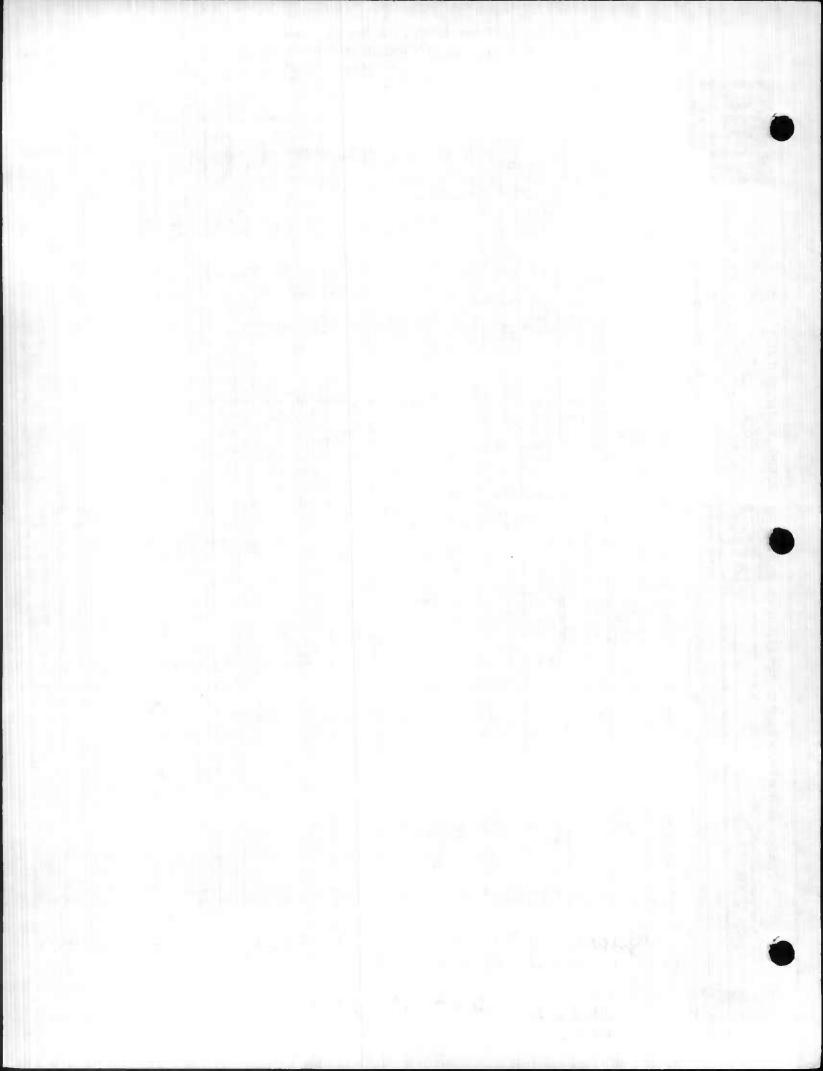
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Deeth 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth Day Month **Physician** MARY VIRGINIA SHIPLEY 20, 1999 JULY 4:52 PM /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, giva street and number) 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE CITY N/A If Undar 1 Yaar Deta of Birth Month Day Year 8/21/1909 If Undar 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdev) Birthplaca (Steta or Foreign Country) 6. Sax **Funeral** Hours Months Deys 1 ☐ M 2 🖾 F 89 Director NORTH CAROLINA 219-32-1491 Usual Residence of Decedent with the Maryland 10d. insida City Limits 10a. State 10c. City. Town or Location 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2800 D KINGS RIDGE ROAD 21234 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Reca - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus Black. White, etc. filed within 72 hours efter 1 Nevar Married 2 Married 1 ☐ Yas 2X No 1 ☐ Yes 2 No Specify: Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Detes: WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) 3 YEARS NURSE HOSPITAL permit. Pages 1 end 2 should be filk Department of Heelth and Mental Hy Important: If item 27 ia marked other any Injury or other traumstic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be ELLEN CHAPPEL BENJAMIN WINSLOW 19b. Meiling Address (Straet end Numbar or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 7819 ELMHURST AVE. BALTIMORE, MD 21234 NANCY W. BRIGHT DAUGHTER altimore, 20b. Plece of Disposition (Nema of 20c. Location - City or Town, Stata 20a. Method of Disposition Deta cematery, cremetory or other place) 1 XBurlal 2 Cramation 3 □ Ramoval from Stete 7/23/99 4 Donation 5 Other (Specify) DULANEY VALLEY MEM. GAR. COCKEYSVILLE, MD 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee THE JOHNSON FUENRAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSO causa of aach lina. lu TOWSON, MD 21286 23a. P. 111. Enter the disease, or compile shock, or haert failura. List only on Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Examiner** Due to (or es e consequence of). Examiner CORONARY ARTERY DISEASE that the death certificate be executed pug buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated asserts) Due to (or as a consequence of) ettending physician I for use es the bune O. Box 68760 Physician/Medical that initiated evants rasulting in deeth) Lest Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? the detach signed by t 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy peed performed' pege 2 hes 2 X No 1 ☐ Yes 2 No 1 Yes this certificate Division of Vital Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Homa 5 Residence 8 Othar (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Menner of Deet Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: After Attending 1. Neturel 5 Pending Investigation e Hospital or Attending 124 hours after death. M Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide a Funeral Certifying Physicien: To the best of my knowledge, death occurred et the time, dete and place, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Cartifian Medical To the within 2 To the I 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura end title of certifian M.D 12561 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANURAG GUPTA GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTIMORE, MD 32. Registrar's Signature 31. Dete filed (Month, Dey, Year) State JUL 27

Registrar

DHMH 16 Rev 6/95

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	5. Social Security N 219-10-		6. Sax 1 ★M 2 ☐ F		'In yrs. last bi 73	Yrs.	Months Days		Min.	8. Data of Bird (Month, Da	y, Year)		place (Stata o
1	Usual Rasidance o				13					Jan.	3,1926	Ma	aryland
- 16	10a. Stata	10b. County		1	Oc. City, Tow	vn or Loc	ation						10d. Insida C
5	Maryland	r	Baltimore	2				D	ında	16			1 🗆 Yas
Director	10e. Street and Nu		YAT CTHIOT 6	-			10f. Zip Coda	DU	Tirda	IK	10g. Citizen of	What Cou	intry?
	2037 Ja		Road					21	1222			ed St	
0	11. Marital Status		12. Was De	cedant Ev	ar in U.S.	13. W	as Decedani of	Hispanic Orlgi	n? (Spe	city Yas or No			ican Indian,
Launerai	1 Navar Marr	iad 2 17 Marri	Armed			16	Yas, specify Cu	ban, Maxican,	Puarto I	Rican, atc.)		ack, Whita	
by	3 Widowed		li Yes, C	Giva V	WWII	1	☐ Yas 2 💢 No	Specify:			Spec	ity: Whi	te
		15. Decedant	's Education		16a	. Deceda	ant's Usual Occ	upation			16b. Kind of		
Be Completed			t grada completad			(Giva k Iifa. D	ind of work don O NOT usa retir	a during most o	of worki	ng	Social	Secu	rity
E	Elemantary/Second 5 Year		Conaga	(1-4or 5+)			Clerk				Admini		-4
9	17. Fathar's Nama	(First, Middla, I	Last)		- 1			18. Mothar	s Nama	(First, Middle,	Maidan Sume	-	
ToB	Louis A	ugusta	Sullivar	1					An	nie Par	nsy Fos	ter	
	19e. Informent's N	ame/Reletions	nip (Type, Print)	-	19	b. Malling	Address (Street	et and Number	or Rura	l Routa Numb	er, City or Tow	n, Stata, Z	ip Code)
	Mrs. Ru	th Sull	Livan/Wif	e		2037	Jasmin	e Road	Du	ndalk,	Maryla	nd 2	1222
	20a. Method of Dis				20b. Placa C	of Dispos	ition (Nema of atory or other p	lace)	i	Date	20c. Location	- City or T	Town, Stata
		☐ Cramation 5 ☐ Other (Sp	3 □Ramoval from	n Stata			Forest		1. 7	/27/99	Owin	as Mi	lls, M
	21. Signature of F	-		1		22.	Nama and Add	rass of Facility					
	14		5/		1		da-Ruck						
\dashv	2 Part Enter t	be die se or	amplications the	t caused th	a death Do		22 Wise					d 21	.222 Approxima
	23 Part. Entart shock, or has	rt fai c e. List	on ona causa or	aach line.	ia daatri. Do	not anta	Tina moda or o	ying, addit as o	arolac c	r raspiratory a	11031,		Interval Be Onsat and
	Immediata Causa		D. /	44	00 110	Di		E.C.	. 0 45	30 C		i	77
	disaasa or condition rasulting in daath)	n	a. PN		ua to (or as a		eural	CIT	131	413			1100
miner			A	den	or as a	consaqu	VOMA	of 1	4	10		1	
-	Constant W. W.	advisor 1	b					UIL	41	7		1	
E	Sequantially list co if any, laading to in cause. Entar Unde	nmadiata		00	ua to (or as a	consequ	iarica or).						
Exam		Injury	C	D	10 to /oc oo o	0000000	anno offi						
Exa	Cause (Disaase or	1	4	Du	a to (or as a	consequ	anca orj:						
Exa	Cause (Disaase or that initiated avants rasulting in death)	S											
Exa	Cause (Disaase or that initiated avants	S	d									1	
Exa	Cause (Disease or that initiated avants rasulting in death)	s Last	d	death hut	not regulting	in the us	derlying causes	iven in Part I		23h Did	tohacco use s	ontribute	to the cause
Exa	Cause (Disaase or that initiated avants	s Last	d	death but r	not rasulting	in the un	derlying causa	givan in Part I.			tobacco use o		
Physician/Medicai Exa	Cause (Disease or that initiated avants rasulting in death)	s Last	d	death but r	not rasulting	in the un	derlying causa (givan in Part I.			tobacco use d		
by Physician/Medical Exa	Cause (Disease or that initiated avants rasulting in death)	s Last	ns contributing to	death but (not rasulting	in the un	derlying causa (givan in Part I.		1 🗆	Yss 2 No	3 □ Pr	obably 4
Physician/Medicai Exa	Cause (Disease or that initiated avants rasulting in death)	s Last	dns contributing to	death but i	not rasulting	in the un	derlying causa (givan in Part I.		1 🗆	Yss 2 No	3 □ Pr	to the cause obably 4 Were autopsy vivaliable prior completion of death?

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicial within 24 hours after death.

To the Funeral Director: After this certi completely filled in by the funeral direct

Medicai Certification: To

State Registrar

Jean-Max 31. Data filed (Month, Day, Year)

29b. Signature and title of certifier

1 Yes 2 No

27. Mannar of Death 1 Natural

2 Accidant

3 Sulcida

29a. Certifier (Check only one)

4 Homicide

Hospital:

5 Panding invastigation

6 Could not be detarmined

1 Inpatient

28a. Data of Injury (Month, Day Year)

29c. License number D 48287

1 Yes 2 □ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

28d. Dascribe how injury occurred

(Physician) D40201 7/25/49

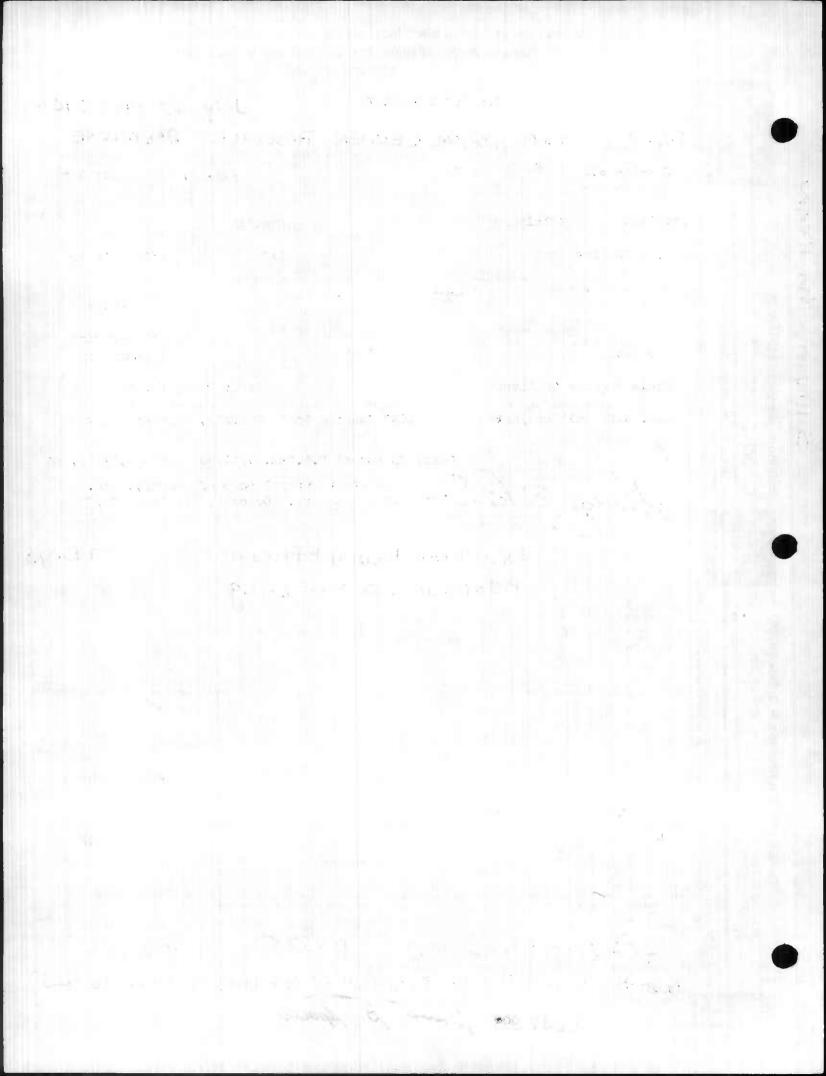
I causa of death (Item 23a) (Type, Print)

YD 9000 FRANKUN SQUARE DRIVE BALTIMORE MD 21237

2 ER/Outpatient 3 DOA

28b. Tima of Injury

28a. Placa of Injury - At homa, ferm, street, fectory, office building, etc. (Specify)

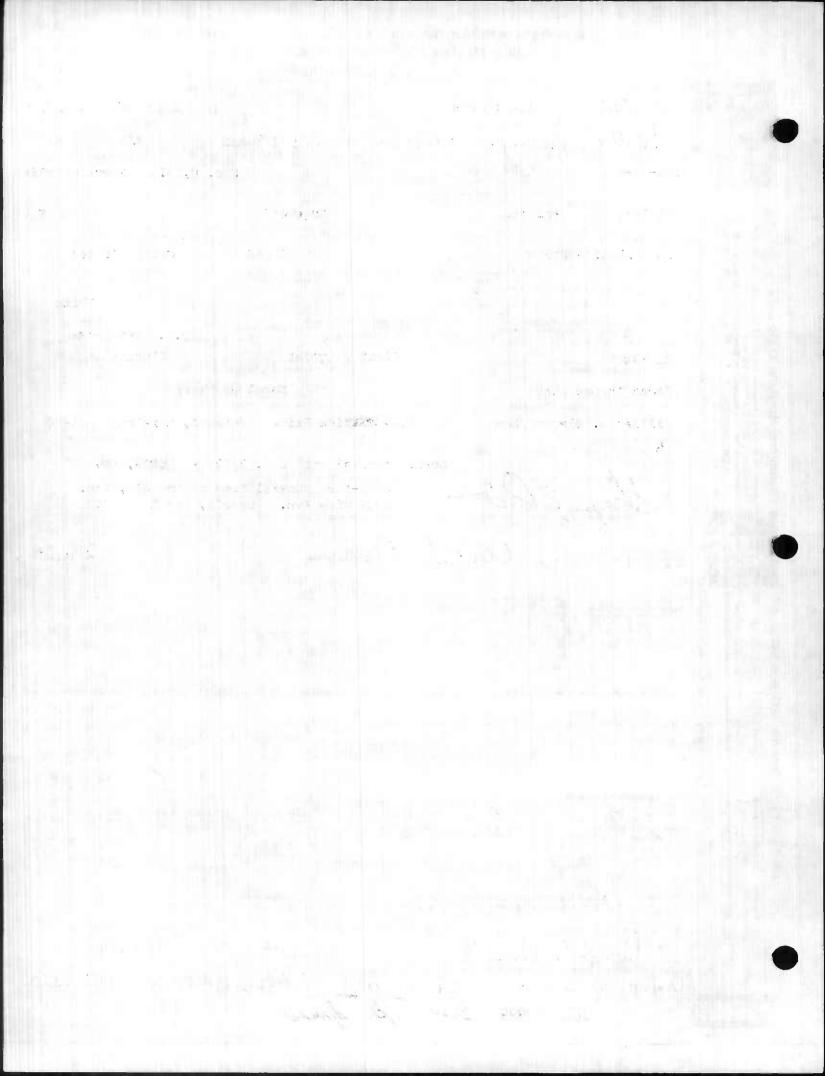


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State of Maryland / Department

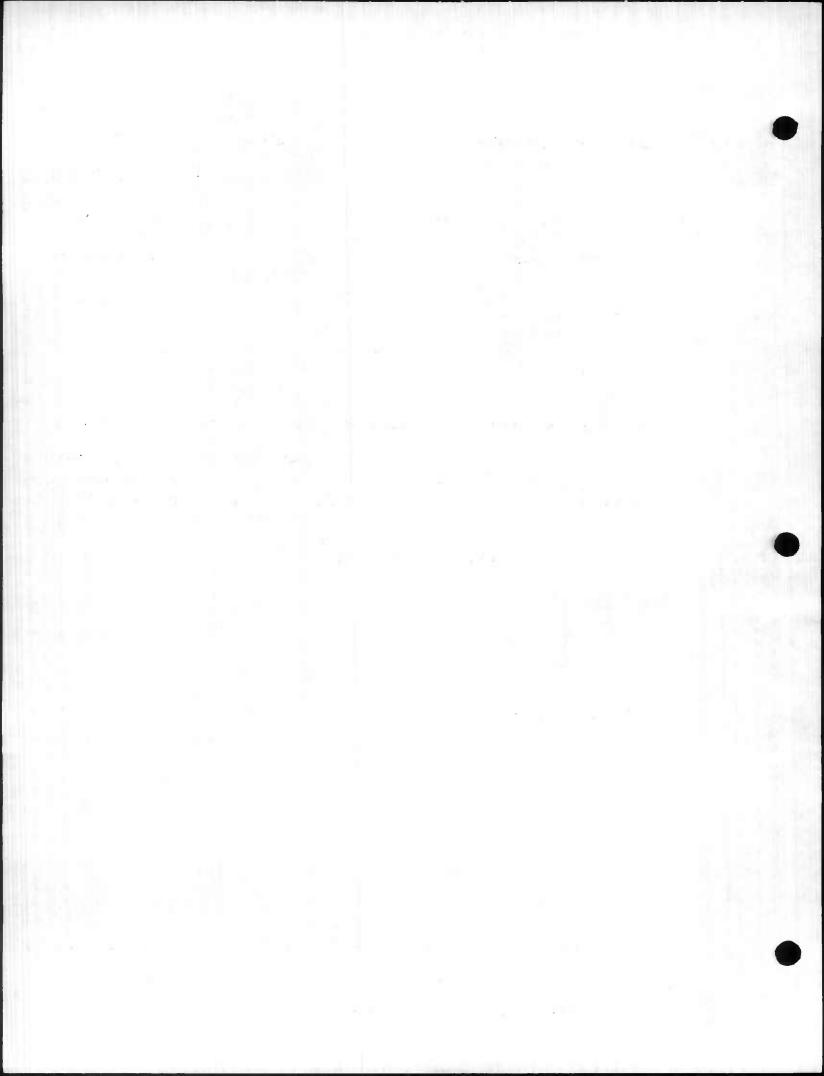
of Death Reg. No.		Drain.			0	la ap
of Health and Mental Hygiene	99	2	3	6	5	2
inc. Addard All debice the m	9.0101					

					viai yiairo		tificate of	Death		Reg. No.	2 6	.0002
ı	Physician	1	1. Decedent's Nama (First, Middla, HELEN	SLATT	ON				2. Data of De Month	Day 23	Year 99	3. Time of Death 2:00 pm
	· /Medica Examine		s Facility Nama (If not institution,	giva street and numb	er)		0	4b. City, Town, or I		th 4c. County		
			1	1EOICAL		NTE	If Under 1 Yea	BALT (M			A/V	In a Court of Familia
L	Funeral Director		5. Social Sacurity Number 244-10-0814 Usual Rasidence of Decedent	. Sax 1 □ M 212 F	Aga (In yrs. la 80	Yrs.	Months Days		(Month, D	8,1918	Nor	place (State or Foreign ptry) th Carolin
	Meryland		10a. Stata 10b. County	Harford	10c. City,	Town or Loc		Edgewood			1	0d. Insida City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28 unit be not		10e. Street and Number 3002 EbbTide D	rive			10f. Zip Coda	2104	0		ed St	ates
21215-0020	filed within 72 hours after death with the Meryland Hygiene. Tratural, or items 23s or 23s-1 show out, the Medical Examinat must be notified as a Commission by Euroscal Director	Di nila	11, Marital Status 1 Navar Marriad 2 Marrier 3 XWidowed 4 Divorced	12. Was Deceda Armed Force 1 Yas 2 If Yas, Giva Yaar or Data	is? ⊒{No		Vas Decedant of Yas, specify Cu ☐ Yas 2☐XNo	Hispanic Origin? (S ban, Maxican, Puart o Specify:	pecify Yas or No o Rican, atc.)	Specif	ce - Amaric ck, White, 'y:	
5-0	natur natur		15. Decedant's (Specify only highast	Education grada complated)		(Giva i	ant's Usual Occi	e during most of wor	king	16b. Kind of B		
121	within the the the the the the the the the the		Elementary/Secondary (0-12)	Collega (1-4	or 5+)		OO NOT use ratir			U.S. A	**	Base
	Hygie ther in		12 Years 17. Fathar's Nama (First, Middla, La	est)		С,	lerk / I	ypist 18. Mothar's Nan	na (First, Middle		rical	
Maryland	should be filed and Mental Hygi marked other imatic event, I	5	James Thomas A					Mahe	1 Washb	urn		
ary	2 should and Men s marks sumatic		19a. Informant's Name/Ralationshi			19b. Maiiin	g Address (Stree	et and Number or Ru			, Stata, Zip	Coda)
	1 and 2 in Health ar em 27 is other trau		William D. Sla	yton/Son		300	EbbTid	le Drive	Edgewoo	d, Mary	land	21040
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any lojury or other traumatic event, the Magnes. To Be Commit		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spa 21. Signature F / Aral Sarvice Lie	cify)	ita ca/	matary, cran	Nama and Add Ouda-Ruc	Park Cem. rass of Facility ck Funeral	. Home c	f Dunda	anton lk, I	nc.
	Physician		23a. Part1. Entar tha Massa, ox shock, or heart Music File or	mplications that cau ily ona causa on aac	sed tha daath. h lina.	Do not anta	/922 Wis	SE AVE. D	or raspiratory	Maryla: arrest,	nd 2	Approximate Interval Between Onset and Death
	/Medicai Examiner		Immediata Causa (Final disaasa or condition rasulting in daath)	a Ge	MCal Dua to (or	as a conseq	OMC uence of):	~			1	2 month
Box 68760,	n certificate be executed and inding physician and use as the burial-transit	2000	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disassa or injury that initiated evants rasulting in death) Last	c		as a consequals s consequals						
	deeth cer e attendir ed for use	2	Part il. Other significant condition	contributing to deat	h but not rasul	ting in the ur	darlying causa o	ivan in Part I.	23b. Dio	tobacco use co	ontribute t	o the cause of death?
, P.O	requires that the deeth cer een signed by the attendin hould be detached for use								1	Yes 2□ No	3 ☐ Pro	bably 4 Dunknown
Records,	2 S S D	Bosold								s an autopsy formed?	av	fere autopsy findings vailable prior to ompletion of cause death?
al H	ystclan: Tha law is certificate has b director, page 2 s								10	Yes 242No	11	☐ Yes 2☐ No
Vital	Physician: this certific ral director,	3	25. Was case referred to medical examiner?	Hospital:				26. Place of Dea	-			
of	> 50 P		1 Yes 25 No 27. Manney of Death 1 Natural 5 Panding 2 Accident invastiga	28a. Data of (Month,		R/Outpatien 28b. Tima of Injury	28c. Inj	4 Li Nursang F		sidanca 6 DOt how injury occu		у)
Division	9 # 5 E		3 Sulcida 6 Could no detarmin	ad 289. Placa of	Injury - At hon atc. (Specify)	ma, farm, str	aat, factory, offic	a		(Street and Num own, Stata)	ber or Run	ai Routa Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in the Madical Cartif	Bollo	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the be aminer: On the basi and manner	s of examination	rledge, death on and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	, and due to the irred at the time	cause(s) and m	nanner as a , and due t	itated. o the cause(s)
	within To the comple		29b. Signature and title of certifier	No				nse number		29d. Date sign	ed (Month,	Day, Year)
			> Thurstat	XVen (D	43934		7/:	23/9	19
			30 Nama and addrass of rson w	no completad causa	301	ST.	PAUL	PLACE	E BA	LITMORI	EM	10 21202
	State Registrar		31. Date filed (Month, Day, Year)	2 7 1999 >	Strar's Signatu	ura	G. de	rack				



					C	ertificate of	Death		Reg. No.		
Т			1. Decedent's Neme (First, Middle, Las	t)				2. Dete of De		V	3. Time of Death
	Physic /Medi		Stanley C	. Sams				July	23. 1	999	7:19 AM
	Exami		4e. Fecility Neme (If not institution, give		·		4b. City, Town, or Lo				7.13
7			Union Memoria	l Hospital			Balti	more		N/A	
t	Funeral		5. Sociel Security Number 6. Se	7. Age (In)	rs. lest birthda	y) If Under 1 Yea	If Under 24 Hrs.	8. Dete of Bir (Month, De	th	9. Birthp	lace (Stete or Foreign
	Director		041-26-1785 Usuel Residence of Decedent	ÚM 2□F	85 Yrs.	Months Deys	Hours Min.	Oct. 3	0, 1913	Lat	iva, Europ
	yow #		10e. State 10b. County	10c.	City, Town or	Location				10	0d. Inside City Limits
	Man	to	Maryland N/	Δ	Baltim	ore					1 X Yes 2 □ No
	ith with the Marylan 23s or 28s-f show ust be notified at	Director	10e. Street end Number		DQ = 0 = 11.7	10f. Zip Code			10g. Citizen of V	Whet Coun	itry?
	With the second	0	2106 Erdman A	Vonuo			21218				States
	eath	era	11. Marital Status	12. Wes Decedent Ever in	n U.S. 1	3 Was Decedent of		ecify Yes or No		e - Americ	
	ter dea Items	Funeral	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🕅 No		If Yes, specify Cu	Hispenic Origin? (Sp ben, Mexican, Puerto	Rican, etc.)	Bled	ck, White,	
Maryland 21215-0020	72 hours after death with the Maryland natural, or items 23s or 28s-f show orest Examiner must be notified as	by I	3 □ Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:		1□ Yes 2💢 No	Specify:		Specify	· Wh	ite
ö	72 hours "natural",	Pa	15. Decedent's Edu		16a De	cedent's Usuel Occu	inetion		16b. Kind of Be		
15	C 6	Be Completed	(Specify only highest grad	le completed)	(Gi	ive kind of work done DO NOT use retire	e during most of work ed)	ing	TOD. KING OF DA	JSHIOSSHIR	lustry
212	filed within Hygiene. other than "	E C	Elementery/Secondery (0-12)	College (1-4or 5+)		Dentist	,		Denti	strv	
D	be filed ntal Hygi d other event,	Ö,	17. Fether's Neme (First, Middle, Last)	7		56110100	18. Mother's Name	e (First, Middle			
an	o d in b	B	Unknown				Unkr			2	
\geq	d 2 should th end Mer 7 is marks traumatic	10	Unknown 19e. Informent's Neme/Reletionship (T.	imo Printl	10h 14	alling Addrson /Ctros	et and Number or Run		ne City or Town	Ctata Tia	Ondal
Ma	. 0 = 3								re. Mary		21218
o o	of Health of Hem 27 is		Helene R. Vest-San 20a. Method of Disposition			06 Erdman	Avenue	Dete	20c. Location -		
ō	0 H 0		1 X Burial 2 ☐ Cremetion 3 ☐ F	Removei from State	cemetery, c	remetory or other pl	,				
Ë	men men lant: jury		4 ☐ Donetion 5 ☐ Other (Specify,		lardens	of Faith	Cemetery	7/31/9	Balt	1 more	e, Maryland
Baltimore,	permit. Page: Depertment of Important: If I any Injury or once.		21. Signeture of Funerel Servica Licens	Michael E. C	anapp	22. Name end Addr	ess of Fecility		5305 1	Harfo	rd Road
ш	205 3 3		Mica C.	Laurash		LEONARD	J. RUCK,	INC.	Baltim	ore.	MD 21214
			23a. Pert1. Enter the diseese, or comp shock, or heert feilure. List only o	licetions thet caused the d	eeth. Do not					,	Approximate
4	Physician		Shock, of fleet lendle. List only o	ne ceuse on eech line.						1	Interval Between Onset and Deeth
9	/Medical		Immediete Cause (Finel	Mercana	lial Ta	faction.				1	7 Days
	Examiner		disease or condition resulting in deeth)			farction					7 Days
		e		Due to	o (or es e cons	sequence of):				i	
	d ansit	Examiner	r	b		1.0				1	
,	certificate be executed ording physician and use as the buriel-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	o (or es e cons	sequenca or):				1	
68760,	sicia bur	cai	Cause (Disease or Injury that initiated events	C	4					i	
89	phy phy s the	edicai	resulting in death) Last	Due to	o (or as a cons	sequence of):					
XO	oding se e	₹		d							
B	death e	ciai						-			
0	that the death of the bod by the etten deteched for u	Physician	Pert II. Other significent conditions co	ntributing to death but not	resulting In the	underlying cause g	iven in Pert I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
9.	that the ed by detection		Anoxic Encephal	opathy				10	Yes 2 No	3 Prob	bably 4 💢 Unknown
of Vital Records,	8 6 8	l by	44 444 444								41 41
0	v requir been s should	Completed						24e. Wes	an eutopsy rmed?	ava	ere autopsy findings allable prior to impletion of cause
ec	2 8 5	du								of c	deeth?
H	The I	0						10	Yes 2 No	1 🗆	Yes 20 No
ita		Be (25. Wes case referred to medical exeminer?				26. Piece of Deetl	h (Check only o	one)		
f V	\$ 00	To	1 ☐ Yes 2 💢 No	Hospitel: 1 X Inpatient 2	□ ER/Outpat	ient 3 DOA	ther: 4 Nursing Ho	me 5 Resi	denca 8 □Oth	er (Specify	()
0	g Ph er thi		27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year		of 28c. Inju			how Injury occur		
Division	Attending in death.	atio	1 XNeturel 5 ☐ Pending investigation	(Month, Day 1 Bar) Injun		Yes 2□No				
Vis	Atte octo by th	ific	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Plece of Injury - A	t home, farm,	street, fectory, office		28f. Location (Street end Numb	er or Rura	Route Number,
Ö	d in Of	Certification:	4 Hofflicide	building, efc. (Spe	ecity)			City or To	wn, Stete)		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physics	alcien: To the best of my i	knowledge, de	eth occurred et the t	ime, dete end plece,	end due to the	cause(s) and me	nner es st	ated.
	24 to Full Jetely	edicai	(Check only 2 Medical Exami	ner: On the basis of exam end manner steted.	inetion end/or	Investigetion, in my	opinion, deeth occurr	ed et the time,	dete end plece,	end due to	the cause(s)
	within 2 To the comple	Me	29b. Signeture end title of certifier			29c. Licen	ise number		29d. Dete signe	d (Month, L	Dey, Year)
	- 5 - Ö		11 911	1	10	47	242 01	141	1. 0.	02	1000
			1 gnd	un n		111	47503	70	July	83	, 1999
			50. Name and address of person who co	impleted cause of death (i	tem 23a) (Typ	e, Print)	ON MEN	mn1A	Hoo	OITA	/
			VERONICA	ompleted cause of death (in E PSTE 1) 32. Registrar's Signature of the state of	v, iu	0 0111	- 7- 1 270	CITE	- 1105/	117	-
	Sta	-	31. Date filed (Month, Day, Year) JUL 2 7 1999	32. Hegistrar's Si	gnatura	South					
	Registr	ai	JOF # 1 1932	/	/ /						

DHMH 16 Rev 6/95

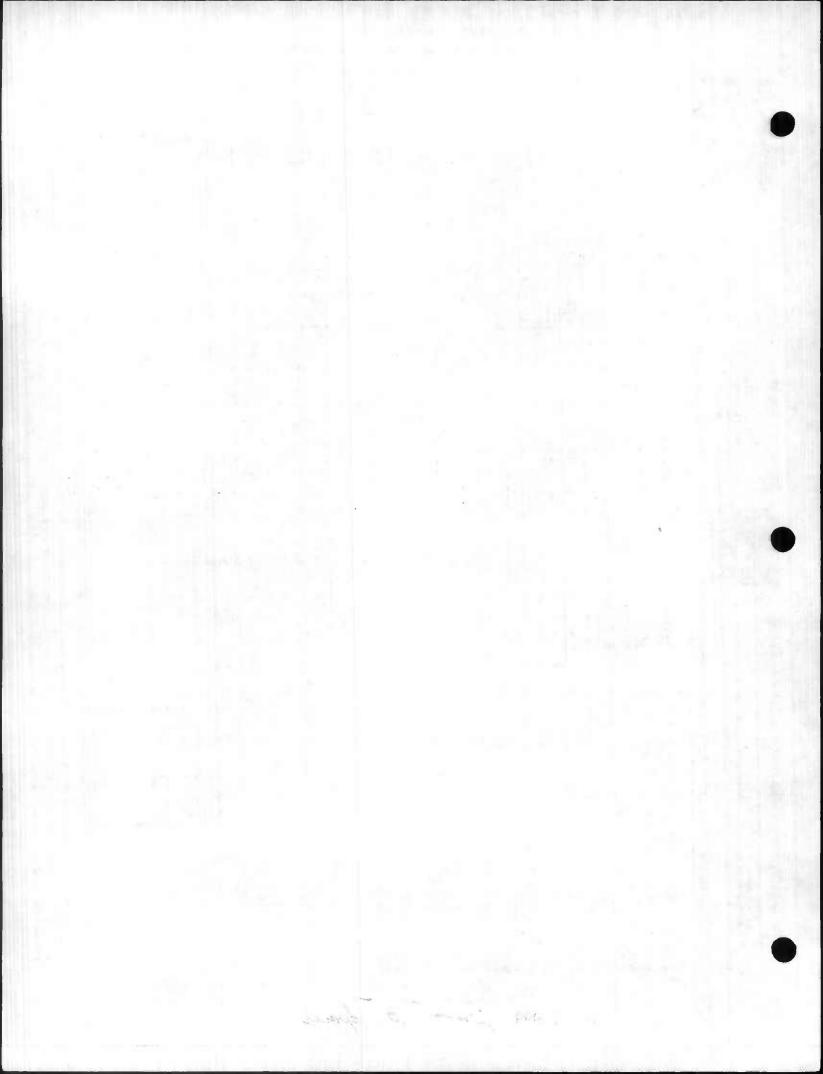


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State of Maryland / Department of Health and Mental Hygiene 9 9 2 3 6 5 1

_						Ce	ertifica	te of	Death		Reg. No.		3634
п	Physicia		1. Decedent's Nama (First, Middle,							2. Date of De Month		Year	3. Time of Death
	/Medica	al .	Virginia A.							July		99	2:25AM
	Examine	r	4a Facility Neme (If not institution,	giva street and number)				4b. City, Town, or	Location of Deat			
1			1318 Maple Av	enue					Arbutus		Balti	more	
	Funeral Director		5. Social Security Number 212-03-9818 Usual Rasidence of Decedent	1. Sex 7. A 1 M 2€XF	ge (In yrs. 88	last birthday Yrs.	Months	Days	If Under 24 Hrs Hours Min.	8. Data of Bir (Month, Da OCt. 3	th Year) 1910	9. Birtho Cour Mary	place (Stata or Foreign http:) 7 Land
	how how		10a. State 10b. County		10c. Cit	y, Town or L	ocation					1	0d. Inside City Limits
	M A	Director	Maryland Baltin	nore	Art	outus							1 Yes 2 No
	th th	P.C	10e. Street and Number				10f. Z	p Code			10g. Citizen of Wi	nat Cour	ntry?
	23a		1318 Maple Ave	nue			2	1227			United	Sta	ates
Maryland 21215-0020	9 0 9 .	by Funeral	11. Marital Status 1 Nevar Merried 2 Merrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yas 2 1 H Yes, Give Year or Dates:	7	S. 13.			lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Specific	Americ Whita, Whita	
9	natural,	2	15. Decedent's	Education		16a. Deci	edent's Usi	al Occup	etion		16b. Kind of Bus	iness/In	dustry
215	Z uic	Completed	(Specify only highast Elementary/Secondary (0-12)		Ed	(Giv	DO NOT	ork done ise retire	during most of word)	rking	,		
21	in the	E	8	College (1-4or	D+)	Home	maker				Own Ho	me	
P	be filed within tal Hygiene. d other than avent, my Me	20	17. Father's Name (First, Middle, La	est)					18. Mother's Nar	me (First, Middle	Maiden Sumame)	
a		0	Lawrence Leo	Farrell					Myrtle	Alene S	Springfie	1d	
2	SPEE	-	19a. Informant's Name/Relationship	(Type, Print)		19b, Mail	ling Addres	s (Street	and Number or Ri	ural Route Numb	er, City or Town, S	tate. Zio	Code)
Ž		1	John J. Stemble			1			enue Arb				
a,	or other tr	1	20a. Method of Disposition			lace of Disp	position (Na	me of		Date	20c. Location - C	ity or To	own, Stata
Baltimore,	Seges F: K	-	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			emetery, cri				7/27/99	Baltimo	ro	MD
	Department Period Insportant: Pe	-	21. Signature of Funeral Service Li		LOI	udon F					neral Ho		
Ba	permit. Peges 1 and 2 Department of Heelth, Important: If Itam 27 is any Injury or other tra price.		Jean A.	Somber	W	1	328 8	ulph	ur Sprin	g Road A	Arbutus,		
			23a. Part1. Entar tha disaase, or co shock, or haart failura. List or	emplications that cause aly one cause on each !	d the deat ine.	h. Do not er	nter the mo	de of dyi	ng, such as cardia	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner	Examiner	Immediata Causa (Final disease or condition resulting in death)	a		r as a conse	equence of	E	Den	uta		1 1 1	
Box 68760,	physicia the bu	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or	r as a conse	quence of)	:					
	death e atter ed for u	200	Part II. Other algnificant conditions	contributing to death b	nut not res	ulting in the	underlyina	causa ni	en in Part I	23b. Did	tohacco use cont	ribute t	o the cause of death?
, P.O.	requires that the death certificent signed by the attending hould be detached for use as	Dy Physiciany		John String to Country		and a second	uncony ny	under gr					bebly 4 Unknown
Records,	aw requisite been 2 should	Completed D								24a. Was	an autopsy omed?	av co	ere autopsy findings allable prior to impletion of cause death?
-	The page	3								10	Yes DE No	1 [☐ Yas 2☐ No
Vital	Startific exting		25. Was case rafarred to medical axaminar?						26. Place of De	ath (Check only	one)		
of o	Physician: this certific ral director,	2	1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatie	ant 3000	OA Ot	er: 4 Nursing F	iome 5ACResi	dence 6 Other	(Specil	(y)
	Attending Pt or death. ector: After th by the funera	ation:	27. Mannar of Death Natural 5 Pending 2 Accident invastiga	28a. Date of Inju (Month, Date)	ry y Year)	28b. Time Injury	of M	28c. Inju Wo 1	yat k? Yes 2 □ No	28d. Describe	how injury occurre	d	
in a	tal or Attanding P. rs after death. al Director: After to led in by the funera		3 Suicide 6 Could no datamin		jury - At ho c. (Specify	ome, farm, s	treet, facto	y, office		28f. Location (City or To	Street and Number wn, Stata)	r or Run	al Routa Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Martical Cartification: To Be Com-		29a. Certifying (Check only one) Certifying 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f axaminal	wledge, dea tion and/or is	th occurred nvestigation	l at the tin	me, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and man data and place, ar	ner as s nd due to	tated. the cause(s)
	Vithin Vithin Somple		29b. Signatura and title of certifier				29	c. Licens	e number		29d. Date signed	(Month,	Day, Year)
	FSFO		milde	2	148	0	7	> 5	072	7	Tilu 2	1	1990
	10	-	30. Neme and address of person wh	o completed cause of a	leath (Item	23a) (Type	, Print)				المال	0) ' (/ /
			Michael Gall	9/	1	atz	A	C. le 1	B 14	00.000	MD 2	12	29
ľ	State Registrar		31. Data filed (Month, Day, Year)	32. Regist	ar's Signa	ture	4	1	V 1	1-100			

DHMH 16 Ray 6/95



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	THE RESIDENCE OF THE PARTY OF T	-	
State of Maryland / Department o	f Health and Mental Hygien	00	20000
3 PART I, II, 27 PER MEO G774 8-4-99 WR. Certificate of	of Death Reg. No	».	23655
1. Decedent's Nama (First, Middle, Last) Theodruc Lee Tucker	2. Date of Death Month De July 19	ry Year 1999	3. Time of Death 11:55 AM.
4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Death 4c	. County of Death	

Physician /Medical Examiner

Tucker AMEND: #23 PART I, II.

1105 East Preston Street 7. Age (Ip yrs. last birthday) 5. Social Security Number

1 M 2□ F

Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours

10f. Zip Code

Yes 2 No

N/A Birthplace (State or Foreign Country)

10g. Citizen of What Country?

U.S. A

Funeral Director

28a-f ahon

"natural", or items 23s or 28s-f abovedical Examiner must be notified at

pernit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Examina-

Baltimore, Maryland 21215-0020

Director

Funeral

b

Completed

Be

Physician/Medical Examiner

þ

Medical Certification: To Be Completed

with the Maryland

death

Usual Residence of Decedent 10a. Stete 10b. County A

10c. City, Town or Location

Yrs.

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 1105

11. Maritel Stetus

214 56 7292

1001

21202 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify:

14. Race - American Indian, Black

1 Never Married 2 Merried 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 Dayas 2 □ No if Yes, Give Yaar or Dates: 15. Decedent's Education (Specify only highest grada completed)

(0 p. Grane 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 0

College (1-4or 5+)

Opernfor RAN 9 18. Mother's Name (First, Middle, Maiden Sumame)

17. Father's Neme (First, Middle, Last)

SAM Wel 19a. Informant's Name/Relationship (Type, Print)

15 5, 5 To 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Epsom Rd Bel 15 ml 2126

20a. Method of Disposition 1.28 Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of pemetery, crematory or other place) arrison Forest Ce

20c. Location - City or Town, State 1 way

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Locks 1

22. Name and Addrass of Facility · dechi

Physician /Medicai Examiner

physician and the burial-transit

980

The law requires that the death certificate be assocuted

Box 68760.

P.0.

Division of Vital Records.

or Attanding Physician:

Hospital

To the !

this

After

within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest

Immediate Cause (Final disaese or condition resulting In death)

MENINGITIS	COMPLICATING	METASTATIC	LUNG	CARCINOMA

Due to (or as a consequence ot):

23a. Pairf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line.

500

Due to (or as e consequenca ot)

Dua to (or as a consequence of):

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

HUMAN IMMUNODEFICIENCY VIRAL INFECTION CHRONIC NARCOTISM

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

UE Yes 2□ No

1/2 (Yes 2 No

25. Was case reterred to medical examiner? examiner r 1 Yes 2 No

27. Menner of Death

1 Natural

2 Accident

3 Suicide

4 Homlcide

28a. Deta of Injury (Month, Dey Year) 5 Pending investigation

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signeture and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

6 Could not be determined

O.C.M.E.

1 ☐ Yes 2 ☐ No

July 20, 1999

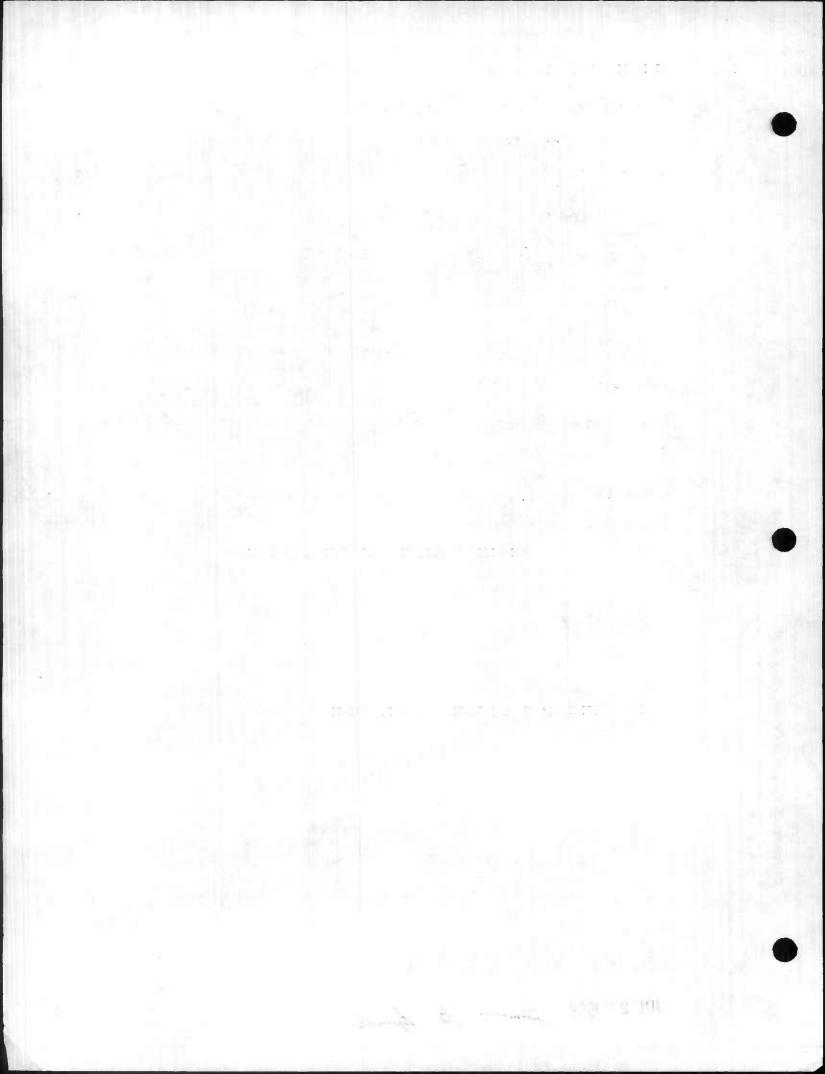
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Radentz

Stephen 31. Data 194 (Month, Dev. Year)

111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signeture 100ch

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Daath 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month **Physician** Violet Pearl Tokarski 1999 JU 23 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner Roseau II Undar 24 Hrs. 8. Data of Birth (Month, Day). tranklin bitai enter IMORE Marc 7. Aga (In yrs. lest birthday) 64 Yrs. If Undar 5. Social Security Number 9. Birthplaca (Stata or Foraign **Funeral** Days Months Maryland 1ĎM **X**□ F 1935 Director 216-32-6853 Usual Rasidanca of Dacedant 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County na 23a or 28a-f ahow must be notified at 1 ☐ Yas 2 ☐ No Director MD NA Baltimore 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda U.S. OT Auto-o- 14. Raca - Amarican Ir Black, Whita, atc. 1424 Bonsal Street 21224 of America Funeral 12. Was Decedent Evar in U,S. Armed Forces?
1 Yas 2 No r than "natural", or items the Medical Examiner ma 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Nevar Married 2 Married 1 Yas 2 If Yas, Giva 1 Yas 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Home Maker Own Home 6 NA 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Driggers George Hisky Loretta 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Albert Tokarski (Husband) 1424 Bonsal Street Baltimore, Md. 21224 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition

T□ Burlal 2 □ Cramation 3 □ Ramoval from Stata July 8 28 4 ☐ Donation 5 ☐ Othar (Specify) Holy Rosary Dundalk, Maryland 21. Signatura of Funaral Sarvice Licanse 22. Nama and Addrass of Facility W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224 23a. Part 1. Entar tha disaasa, or complications that caused tha daath. Do not entar the mode of dying, such as cardiac or respiretory arrest shock or haart failura. List only one cause of each line. Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final 16 Days disaasa or condition rasulting In daath) Examiner Due to (or es a consequance of): Examiner Resistant Staby Lococcus Aureus physician and s the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Diseasa or Injury that initiated avants rasulting in death) Last Dua to (or es a consequança of): Physician/Medicai Dua to (or as a consequanca of) 60 089 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 2 No † Tyes 1 Yes 2 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 8 □Othar (Specify) Lo 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 5 Pending investigetion Injury 1 Natural 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacity) completaly filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one)

State Registrar

DHMH 16 Rev 6/95

death with the Marylenc

Pages 1 end 2 should be filed within and Health and Mental Hygiene.

Department of Important: If

The law requiras that the death certificate be axecuted

cartificate

After this

24 hours after death.

To the Vithin 2

P.O. Box 68760,

Records,

Division of Vital

Hospital or Attending Physician:

10 Kavski, VIO

29b. Signature and title of certifier

31. Data filad (Month, Day, Year)

or Kevin

72

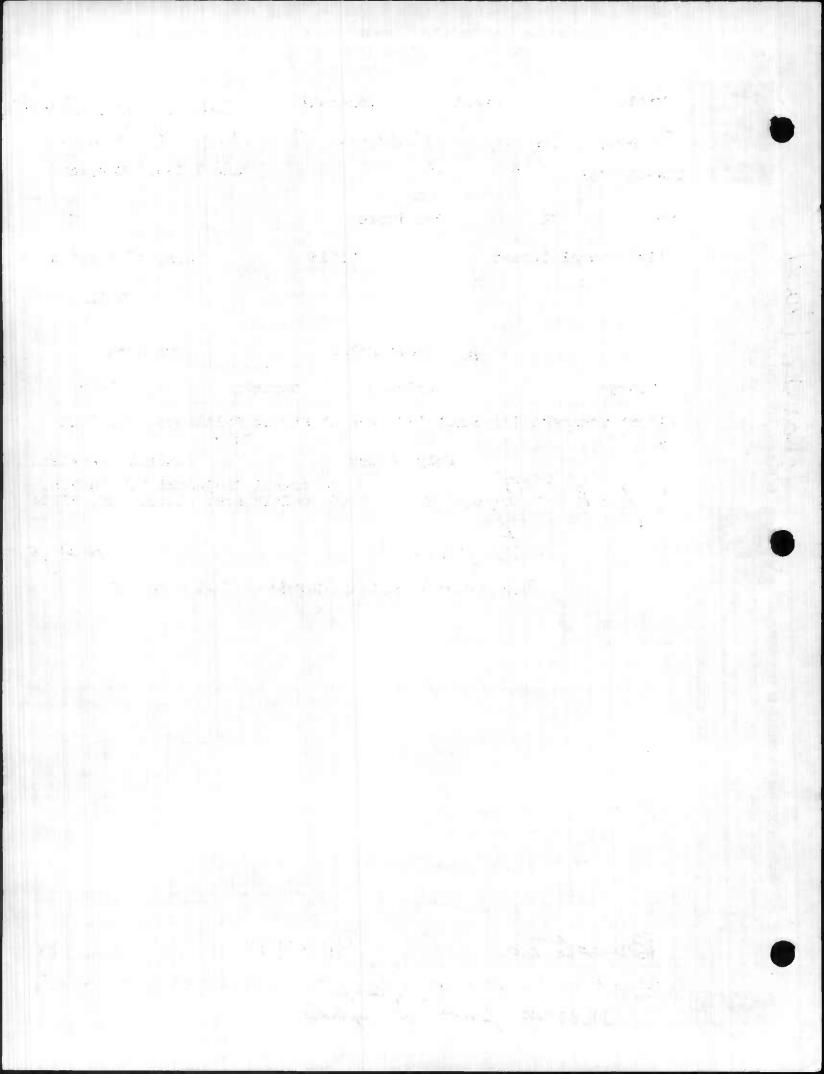
Brewster

30. Nama and addrass of person who complated cause of daath (Itam 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, Maryland 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMENDED ITEM #5 BER FH G773 7/28/99 State of Maryland / Department of Health and Mental Hygiene O

in the control of the	icalli and	Mondairi	gione	0		
tificate of	Death		Reg. No.	J	2	

23657

3. Time of Death

1 ☐ Yes XX No

Physician /Medical Examiner

9:45 AM

Funeral

Usual Residence of Decedent

 Birthplace (State or Foreign Country) Pennsylvania

Director

ahow Director Funeral

à

Completed

Be

9

"natural", or items 23a or 28a-f ahor filed within 72 hours after

Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked off = 8 Department of Important: If any injury or

Baitimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vitai Records,

Hospital

Physician /Medicai Examiner

Examiner The law requires that the death certificate be executed and physician the burial edical an/Me for use been signed by the should be detached Compl page 2 Physician: funeral director, Be Certification: To this Attending within 24 hours after death. To the Funeral Director: A filled in by ò

2. Date of Death 1. Decedent's Nama (First, Middle, Last) 21, 1999 Month JULY Edna B. Thomas 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9403 MICHAEL DRIVE PRINCE GEORGES CLINTON 5 Social Security Number If Under 24 Hrs. 8. Date of Birth

Month, Day, Year)

June 20, 1926 If Under 1 Year 7. Age (In yrs. last birthday) Months Days Hours 1 M 20XF Yrs 73 202-18-0335 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 9403 Michael Drive 20735 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 1 Yes 3 No Specify: Specify: 30€Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Berwin A. Taylor Edna S. Manuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 Old Federal Hill Road, Jarrettsville, Md.21084 Susan Thomas (daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 7/26/99 Jarrettsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Watters Mem. U.M.C. wm. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bruzdzinski Funeral HOme, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiovascular Disease Associated a. Atheroscleropic disease or condition resulting in death) with nuronmental Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? propert 1 Yes

24b. Ware autopsy lindings available prior to completion of cause of death? 1 Ves 2 No

Approximate Interval Between Onset and Death

25. Was case referred to medical axaminar? XXYes 2□ No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 7-21-99

28b. Time of Francisco 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 PNo

26. Place of Death (Check only one)

Other: 4 Nursing Homa XX Residence 6 Other (Specify) 28d. Describe how, injury occurred exposure to environmental heat

28f. Location (Street and Number or Rural Route Nyaber, City or Town, State) 9403 McChael Will

29a. Certifier (Check only one)

Medical

State Registrar

completely

1 Natoral

3 Suicide

2 Accident

4 Homicide

Clinton, home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified Mutor ennus

6 Could not be determined

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) 22, 1999 JULY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 sute no Jenni3

31. Date liled (Month, Day, Year)

32. Registrar's Signature

7 1999

Sporks

988 7 4 101

1 2 2 2 2

DHMH 16 Ray 6/95

State

Registrar

111 Penn Street, Baltimore, Maryland 21201

30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print)

5.

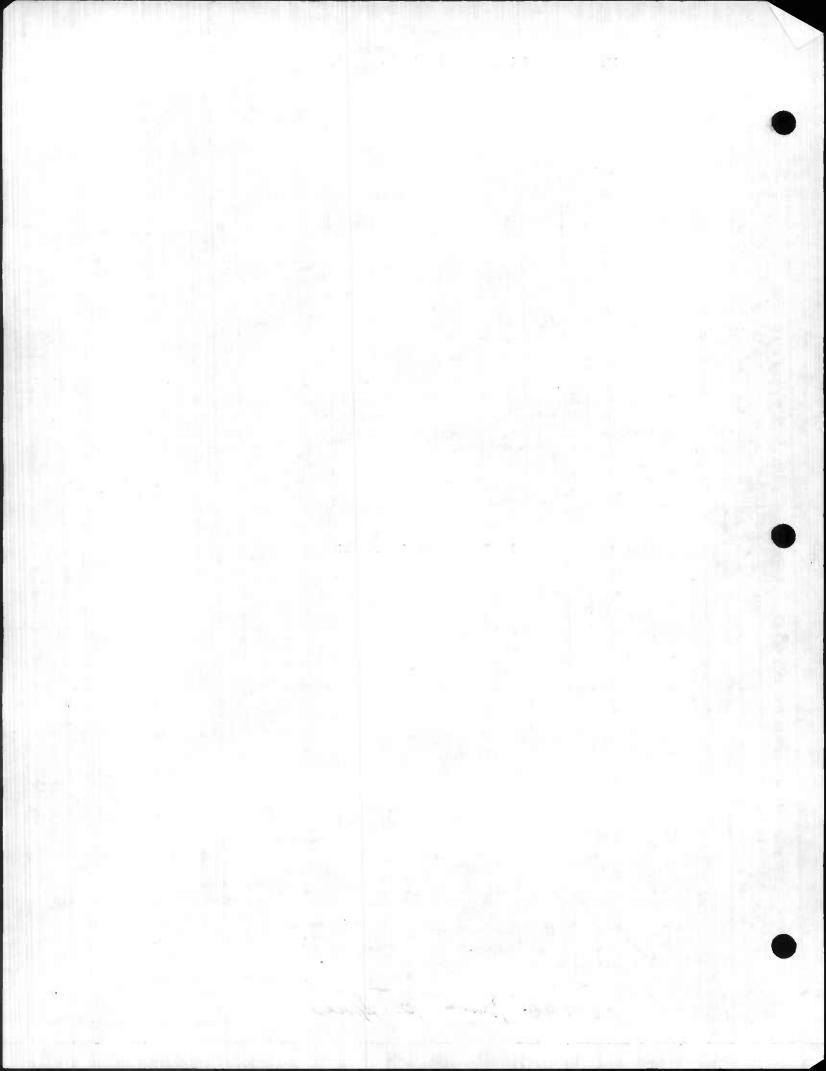
JUL 27 1999

Stropen S.
31. Dete filed (Month, Day, Year)

Radentz

32. Aggistrar's Signatura

Ener



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JOHN G. WHITMAN 0/ **Physician** 4b. City, Town, or Location of Death /Medical Am 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NONTHWEST HOSPITAL CENTER BALTIMORE 5. Social Security Number If Under 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1月M 2□F Months 218-07-0087 84 10-21-1914 Director MARYLAND **Usual Residence of Decedent** the Meryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at MD. BALTIMORE **OWINGS** MILLS 1 Yas 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 11534 GARRISON FOREST ROAD 21117 Items 23a death Funeral 12. Was Decedent Ever in U,S. Armed Forces?

XXYes 2 No 1943
N Yes, Give
Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Peges 1 and 2 ahould be filed within 72 hours after c Department of Health and Mental Hyglene. Important: if Item 27 le marked other than "natural", or Item any Injury or other treumatic event, the Medical Example Black, Whita, etc. 1 Never Married Married WHITE 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BUILDING College (1-4or 5+)
YEARS Elementary/Secondary (0-12) MARKETING EXECUTIVE MATERIALS 4 land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 EZRA BAILEY WHITMAN FANNY GLENN 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 FANNY L.WHITMAN (WIFE) 11534 GARRISON FOREST RD., OWINGS MILLS, MD. Baitimore. 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 20c. Location - City or Town, State itery, crematory or other place) 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GREEN MOUNT CREMATORY 2-22 BALTO., MD., 21202 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HENRY W. JENKINS AND SONS COMPANY R. S. Ruth 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** CEREBROVAS CULAR ACCIONAT 2 0445 Immediate Cause (Final disease or condition resulting in death) /Medicai Examine Examiner physician and the burtel-tranait death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 35x 68760 Physician/Medical Due to (or as a consequence of): 980 Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobecco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown DNEUMANIA Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 P. 1 □ Yes 2 □ No Division of Vitai Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 5 Pending investigation Attending V Naturat To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one)

State Registrar

29b. Signature and title of certifier

ORIANDO 31. Date filed (Month, Day, Year)

JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COVANAN

32. Registrer's Signature

DHMH 16 Rev 6/95

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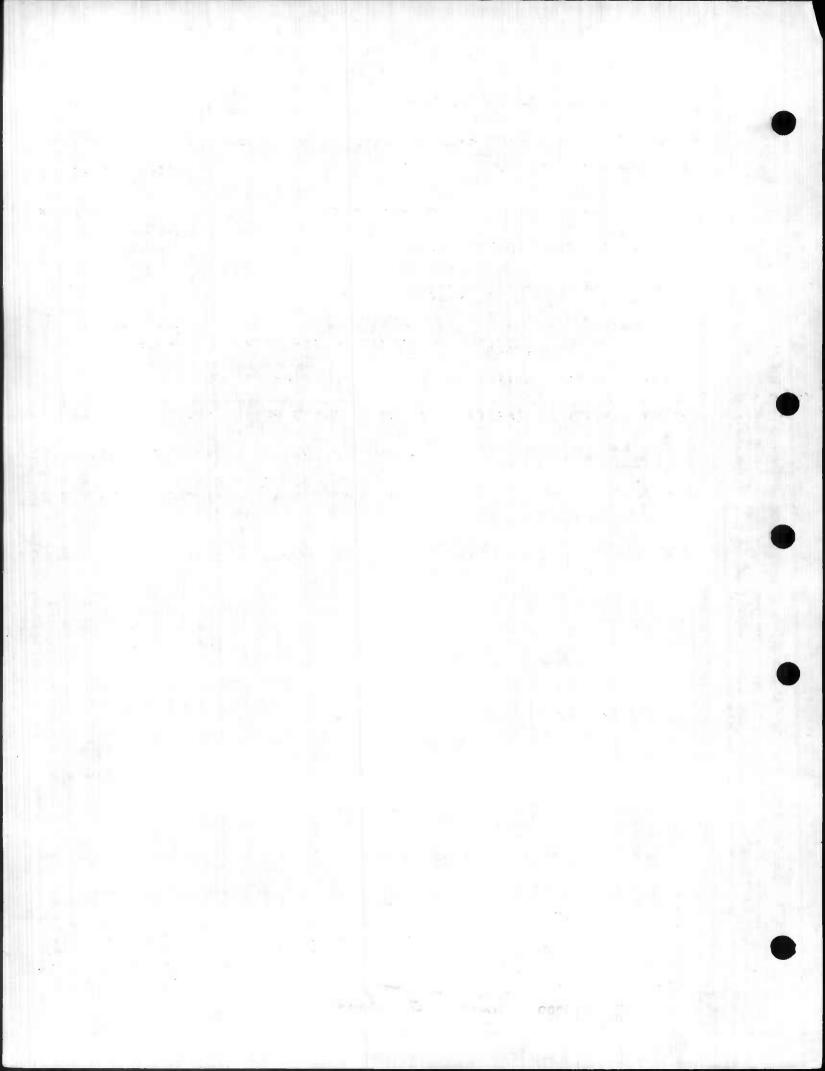
(ur)

and

29d. Date signed (Month, Day, Year)

ZANDALISTAND, UN 2/33

July 21, 1999



Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death TOLY **Physician** Wilbert Dennis Woodard 5-50pm 1999 /Medical 4a Facility Neme (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTH PRUNDEL HOSPITAL ATVINE ARUNDEL GLEON BURDYTE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 181–32–7132 8. Date of Birth (Month, Day, Year) Feb. 17,1942 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Pennsylvania Director Usuel Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at MD Anne Arundel Glen Burnie 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7982 Nolcrest Road 21061 USA Nerna 23a 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Evar in U,S. Armed Forces? 11. Marital Status Black, White, etc. MYas 2 No 1 ☐ Never Merriad 2 ☐ Merried Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: **Black** à 3 Widowed 4 Divorced Year or DetasVietnam Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Postal Clerk US Post Office 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Willie Coleman Sara Woodard 19a. Informant's Name/Relationship (Type, Print)
Irma Jean Woodard (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is any Injury or other trau 7982 Nolcrest Road, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 07/28 Crownsville, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee allech 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel BLEEDING GASTROINTESTINAL disease or condition resulting in death) Examiner TRIC physician and s the burial-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. REMIA edical MAETOWA Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown NON-INSULIN DEPENDENT DIADETES Records, 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? MELLITUS. completion of cause of death? CHRONIC RENAL FAILURE 2 No 1 Yes 25 No Division of Vital 25. Wes case refarred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 ANO Hospitel: 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 28a. Dete of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After I or Attending F after death. I Director: After 1 Avetural
2 Accident 5 Pending investigation 1 Yes 2 No in 24 house.
The Funeral Directory filled in by the 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and menner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) within 2 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier D51664 JULY 30. Name and eddress of person who completed cause of death (them 23e) (Type, Print) SUDHIR KUMPR ASGARWAL MORTH ARVIVOEL HOSPITAL, 30 HOSPITAL DRIVE, GLEN BURNIE, 21061 31. Date tiled (Month, Day, Year)

DHMH 16 Rev 6/95

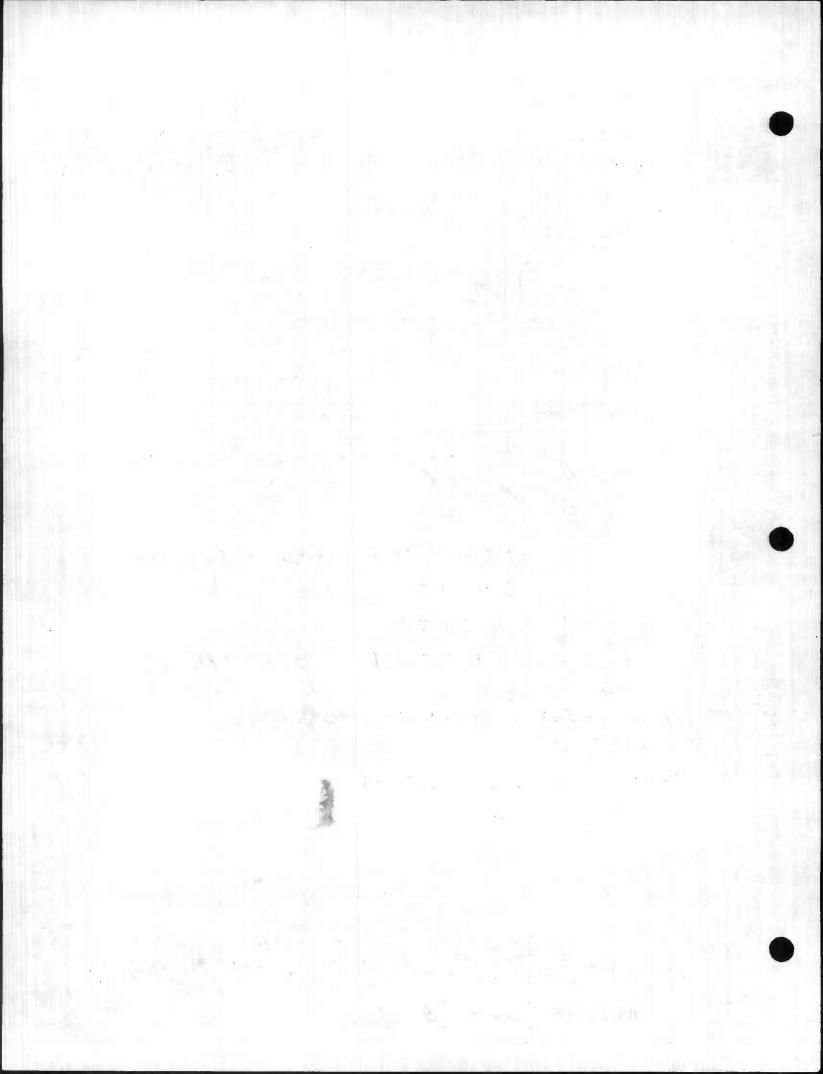
WILBE

ODDMRD

State Registrar

JUL 27 1999

32. Registrar's Signature



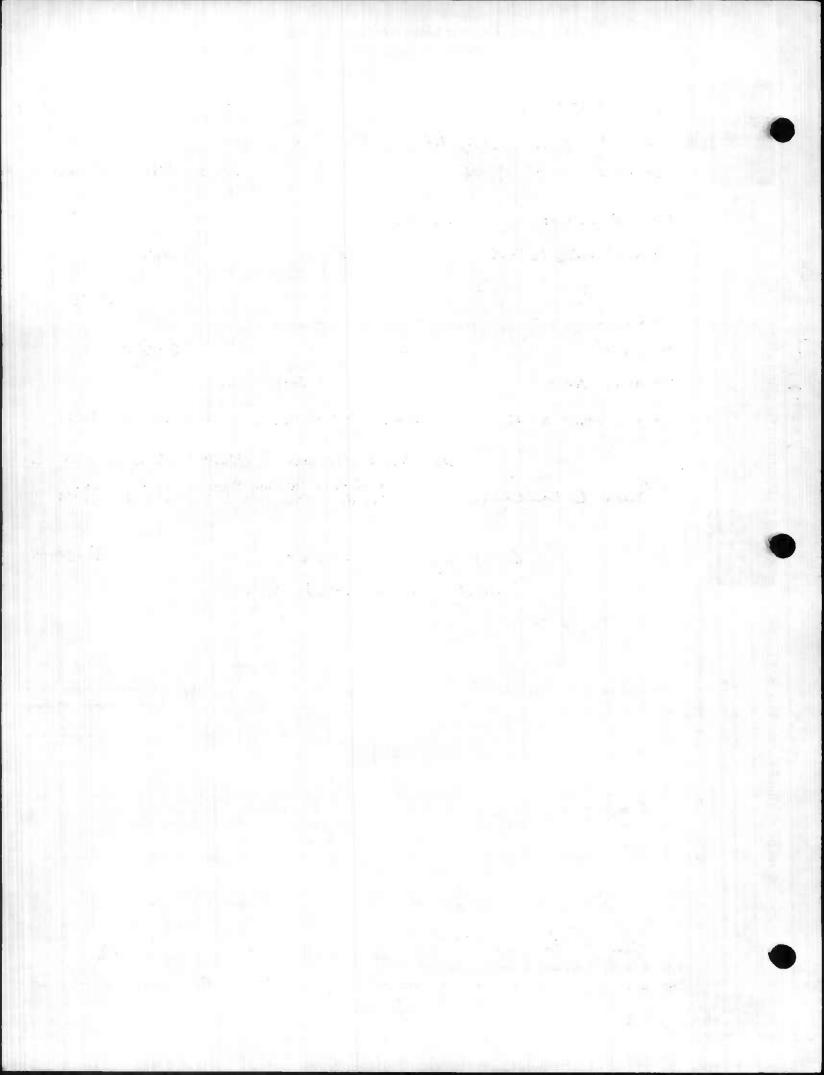
Registrar

State

31. Dete filed (Month, Dey, Year)

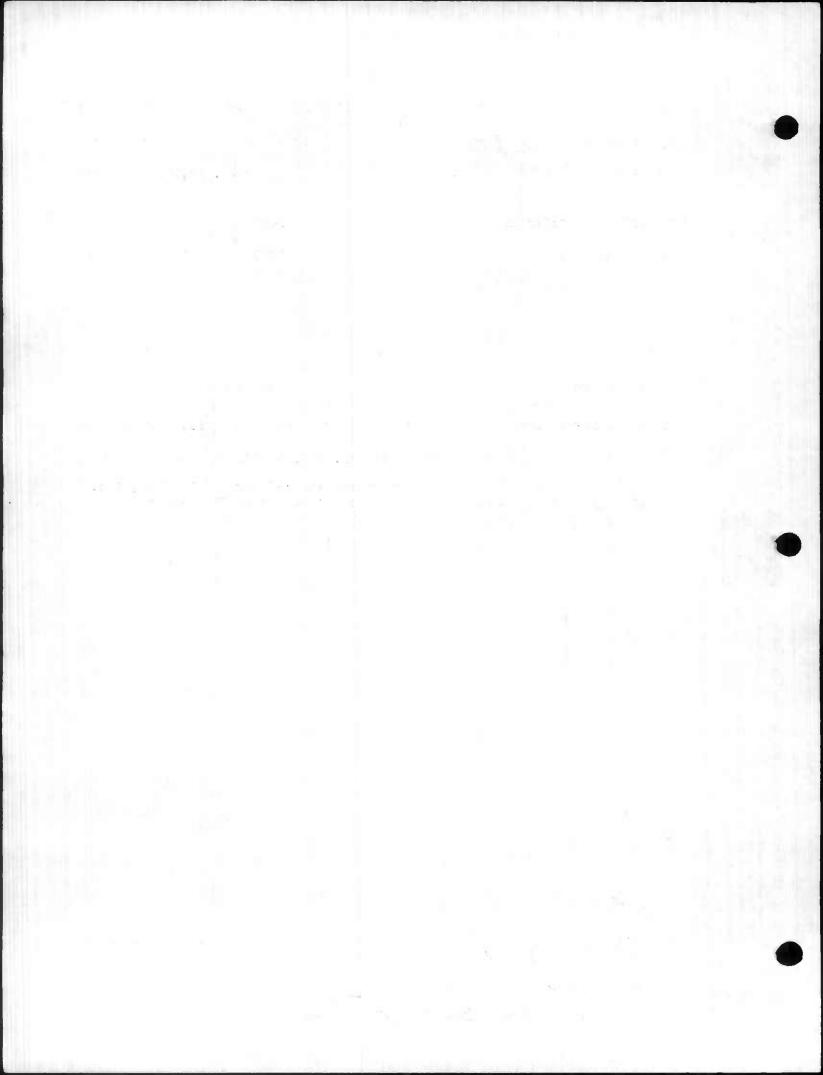
1999

32. Registrer'a Signature



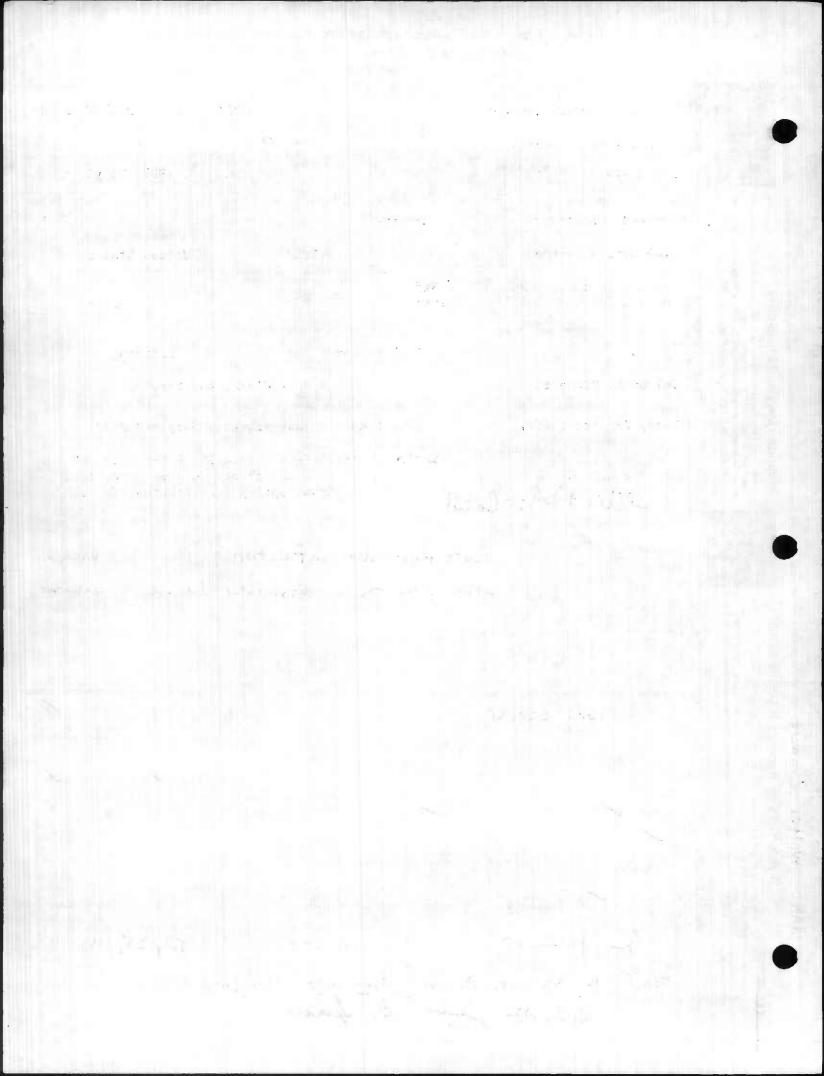
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				viaiyiai		tificate			id Mental Hy	Reg. No.	2	3662		
Physician /Medical		Decedent's Name (First, Middle, Last) MARGARET LORRAINE				ZIMMERMAN			2. Data of De Month July	23 19	Day 1999		3. Time of Death 2:20 PM	
Examine Funeral Director	er	4a. Facility Nama (If not institution, g/s 7822 Price Lane 5. Social Security Number 219-30-2699	in which was :			If Undar 1 Yaar Months Days		Roseda.	Hrs. 8. Date of Bi	Ва	of Death ltimore 9. Birthplace (Stata or Foreign Country) Maryland			
	tor	Usual Rasidence of Decedent 10a. Stata 10b. County Maryland Ba	altimore	i more					osedale	10d. Inside City Limi				
23a or 28a unit be not	Funeral Director	10e. Street and Number 7822 Price Lane					10f. Zip Code 21237				10g. Citizen of What Country? United States			
al', or items	þ	11. Marital Status 1 ☐ Navar Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceda Armed Force 1 Tes 2 If Yes, Give Year or Date	s? XNo	İ	Was Dacedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer i ☐ Yes 2 ☑ No Specify:			? (Specify Yes or No Puerto Rican, etc.)	Black, White, etc.				
iane. Than *natur The Medical	Completed	(Specify only highast grada completed) (Give life. Elemantary/Secondary (0-12) College (1-4or 5+)				dent's Usual Occupation kind of work done during most of working DO NOT use retired) DIMEMAREY				16b. Kind of Business/Industry Own Home				
Mantal Hyg arked other atic event,	To Be C	17. Father's Nama (First, Middle, Last) Riley Wolford						18. Mother's Nama (First, Middle, Maiden Sumama) Edith Decker						
Department of Health and Mantal Hygiane, Important, or items 23s or 28s-f show Important; if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or F							ve Bel A	ir, Mary 20c Location	land City or Tow	21014 m, State		
Departme importan any injur		21. Signature of Fineral Service Licensaa 22. Name and Address of Facility Duda-Ruck Funeral								27/1999 Middle River, MD Home of Dundalk, Inc. Dundalk, Maryland 21222				
ysician Medical caminer	liner	23a. Part1. Enter the asease, or complications that caused the death. Do not anlar the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediata Causa (Final disease or condition resulting In death) Due to (or as a consequence of):												
physicia as the bur	in/Medical Examiner	Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of):												
d by the	y Physician/M	Part II. Other significant conditions of	sulting In the un	deriying cau	se give	en in Part I.		tobacco use co	ntribute to t	. /	-			
has been sign ga 2 should be	Completed by									performed? available		e autopsy findin able prior to plation of cause eath?	_	
certific rector.	Be	examiner? Hospital:						are .	Death (Check only	N	10	Yes 2□ No		
5 g	Certification: To	1 Yas 2 No 27. Manner of Death 1 Natural 5 Pending Investigation Investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No											
ours after death.		3 Suicida 6 Could not b datermined	building,	28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) an: To the best of my knowledge, death occurred at the time, date and ple				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
within 24 hours af To the Funeral Di completaly filled is	Medicai	(Check only 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occu and manner stated. 29b. Signature and titla of certifier 29c. Licansa number							occurred at the time,	urred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)				
		30. Name and addrass of person who completed cause of death (flor 23a) (Type, Print)												
State Registra		31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	ature	4	Lo	+ 100	1.010	· ·				



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Mary		Certificate			Reg. No.	23663
	1. Decedent's Nama (First, Middla, La	st)	7 15			2. Date of Dea	ith	3. Time of Death
Physician	Walter Julius	Zinnert				Month	Day 2.5	Yaar 1999 0951 AM
/Medical Examiner	4a Facility Name (If not institution, give			7 1 14-1	4b. City, Town, or I		4c. County	
	St. Agnes Hos	pital			Baltimor	e	N/	A
Funeral Director	5. Social Security Number 6. S 212-22-4023 Usuat Residence of Decedent	Sex 7. Aga (Ing	yrs. last birtho 72 Yr	Months Da	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, De) Mar. 14	Year) 1927	9. Birthplaca (State or Foreign Country) Maryland
Na mand	10a. State 10b. County	10c.	City, Town	or Location	-			10d. Inside City Limits
Mary Hah fled	Maryland Baltime	ore	Arb	utus				1 ☐ Yes 2 ₺ No
vith the Mar or 28a-fa on norther Director	10e. Street and Number			10f. Zip Coo	da		10g. Citizan of V	Vhat Country?
th with	5108 Benson Aven	ue			21227		United	States
Baltimore, Maryland 21215-0020 pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hydiene. Important: If team z7 is marked other than "retured", or items 23e or 28e-f show any injury or other traumatic avent, the Madical Evantice must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evar i Armed Forcas? *(2)Yes 2 \sum No 1 / If Yas, Give Year or Dates: 5 /	1945 1946	13. Was Decedent If Yes, specify 0	of Hispanic Origin? (S Cuban, Mexican, Puart No Specify:	pecify Yes or No- o Rican, atc.)	14. Rac Blac Specify	e-Amarican Indian, sk, White, etc.
5-0 72 ho	15. Decedent's E	ducation	16a. D	ecedent's Usual Oc	ccupation	rkina	16b. Kind of B	usiness/Industry
ed within 72 ho year within 72 ho year. How meture it, in wedged Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			one during most of wor stired)	Arrig		
Cor Cor	0		Вос	ok Binder		- 45: 14:4-4:-	Print	
The fill Hand Hand	17. Fathar'a Name (First, Middla, Last, Julius H. Zinner					na (First, Middla, a A. Bor		na)
iryla hould I d Meni marke marke	19a. Informant's Name/Relationship (19h A	Aplling Address (St.	reet and Number or Ru			State Zin Code)
Ma od 2 s od 2 s 27 is 27 is	Nancy Zinnert (W:				Avenue Ar			
s 1 ac f Haa other	20a. Method of Disposition	20	b. Piece of D	Disposition (Name of cremetory or other	Avenue AI	Date		City or Town, Stata
Page minito	1 Burial 2 Cramation 3 4 Donation 5 Other (Special	Hemoval from State		ew Memori		7/28/99	Sykesv	ille, MD
Balti permit. Departm Importm eny inju	21. Signat of Funeral Service Licer	A ha	0		ddress of Facility Am 1phur Spri			ome, Inc. , MD 21227
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.	leath. Do no	t enter the mode of	dying, such as cardiac	c or respiratory ar	rest,	Approximete Intarval Betwean Onset and Death
Physician / /Medical	Immediate Cause (Final	a. h		(achia)	in farct	ian		100 Mag - 10
Examiner	disease or condition resulting in death)			nsequence of):	IN I WEI	1611		unknown
Ja z					ardiovusc	clas di	souse	UNICHOIVA
58760, Cata be associted physician and sthe buriel-transit and cata Examiner	Sequentially list conditions,	0.		nsequence of):	J-1, 00. 0 V 0.30		36-0 -	
50, oe axe cian sounial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events	c						
68760, ficate be aviate the burier in the burier edical E	that Initiated events resulting in death) Last	Due to	o (or as a cor	nsequence of):				
oartific		d					.	
P.O. Box 6 nat the death cartification of by the attending leistched for use as Physician/Me	D. A. D. Caller and J. Williams and Additional		and the same		Description of the second	POP DIA		-Adh-Ac Ac Ab - cours and double
tha da sched	Part II. Other significant conditions of		resulting in t	ne underlying caus	e given in Part i.			ntributs to the cause of death? 3 Probably 4 Onknown
S, P. as that I be deta	lung	cancer					2010	
ord requir						24a. Was perio	an autopsy med?	24b. Wera autopsy findings available prior to completion of cause of death?
Re lav a has sign 2						101	as 2 No	1 🗆 Yes 2 🗖 No
	25. Was case referred to medical				26 Place of Day	ath (Check only o		T T T T T T T T T T T T T T T T T T T
of Vita Of Vita Physician: This cartific rial director,	examiner?	Hospital: 1 ☐ Inpatient	2 DER/Outo	atient 3 DOA	Other:	dome 5 ☐ Resid		er (Specify)
T 0 4 4 18	27. Manner of Death	28e. Date of Injury (Month, Day Yea	28b. Tin		Injury at Work?	28d. Dascribe h		
ion ion nding in Affar rathman funan	1 Accident 5 Pending Investigatio		r) Inje		1 Yes 2 No			
Walt Division of the or attending Parter death and present of the tries of the trie	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Plece of Injury - / building, etc. (Sp	At home, fam	n, street, fectory, off	fice	28f. Location (S City or Tox		per or Rural Routa Number,
ttal o lirs aff								
NAME Walls Division To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my niner: On the basis of exam	knowledge, on ninetion and/	deeth occurred at the or invastigetion, in r	ne time, dete and place my opinion, death occu	a, end due to the durred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
NA or the	29b. Signature and titla of gertifier	end manner stated.		29c. Lic	cansa number		29d. Date slone	d (Month, Day, Year)
± ₹ ± 8	In Fal	- mo			7353			5, 1999
12	30 Name an eddrare of trees it	completed source of death i	Itam 22e1 /F		1117			7
		10. Cetan Ave	nve	Balty	note, Ma	ryland	21229	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrars S	ignature	B. 4	raks			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:35 AL Tis BEAN 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) | fl Under 1 Year | fl Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Manth, Day, Year) Jul 19, 1923 9. Birthplace (State or Foreign Country) 15 M 2□ F 75 Yrs. 110-18-1683 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 9314 Michaels Way 21042 USA 12. Was Decedent Ever in U,S. Agned Forces? 1. Yes, Give Year or Dates: WW II & 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Merital Status 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced KOTE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Material Standard Ofc CSX Railroad 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) (Peer) Blanche Jacob Bean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9314 Michaels Way; Ellicott City MD 21042 19a. Informant's Name/Relationship (Type, Print) Eleanor E. Bean 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Laurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SS Peter Paul Cemetery7/17/ Cumberland, MD 21. Signature of Funeral Service Licenses 22Scarperii Faraneral Home P.A. Cumberland, Maryland 23a. Pert1. Enter the diselves, or combifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List buty one cause on each line. Approximete fnterval Between Onset and Death Immediate Cause (Final 72 HRS ACUTE RBNAL FAILURE diseese or condition resulting in death) Due to (or as a consequence of): 72 HRS MULTIPLE CARDIAG EMBOLI Due to (or as a consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury DAY ONSET ATRIAL that initiated events resulting in death) Last Due to (or es a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? STATUS POST AMPUTATION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy SPINAL CORD PROBABOR 1 Yes 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one)

Examiner physician and the burial-transit the death certificate be executed Box 68760. Physician/Medical 98 P.O. Records, þ Completed of Vital Medical Certification: To this After Division or Attending n 24 hours after death.

Ne Funeral Director: After pletely filled in by the fun

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

8

Funeral

Director

the Menyland

Pages 1 and 2 should be filed within 72 hours after death with the Meryla nest of Heelih and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or frame 23a or 28a-f show that: if Item 27 is marked other than "natural", or frame 10 and 10 an

Department of important: If eny injury or once.

Physician /Medical

Examiner

21215-0020

Baltimore, Maryland

GANGRANA OF CBG 25. Was case referred to medical

1 Yes 2 No	Hospital:	2 ER/Outpatient	3 🗆 i	DOA Other: 4 Nursin	g Home 5 Residence 6 Other (Specify)
Z LI ACCIDENT	tigation	28b. Time of fnjury	М	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could determ	28e. Place of Injury - building, etc. (S)	At home, farm, street oecify)	t, fect	ory, office	28f, Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

31. Date filed (Month, Day, Year)

₹ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier L Seisen NO

JUL I 4 1999

29c. License number D17502

RIDGE

RD

29d. Date signed (Month, Day, Year) 7.12.99

COLUMBIA

21044

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10802 HICKORY RBNE'L GBZBBR MYD

32. Registrar's Signature

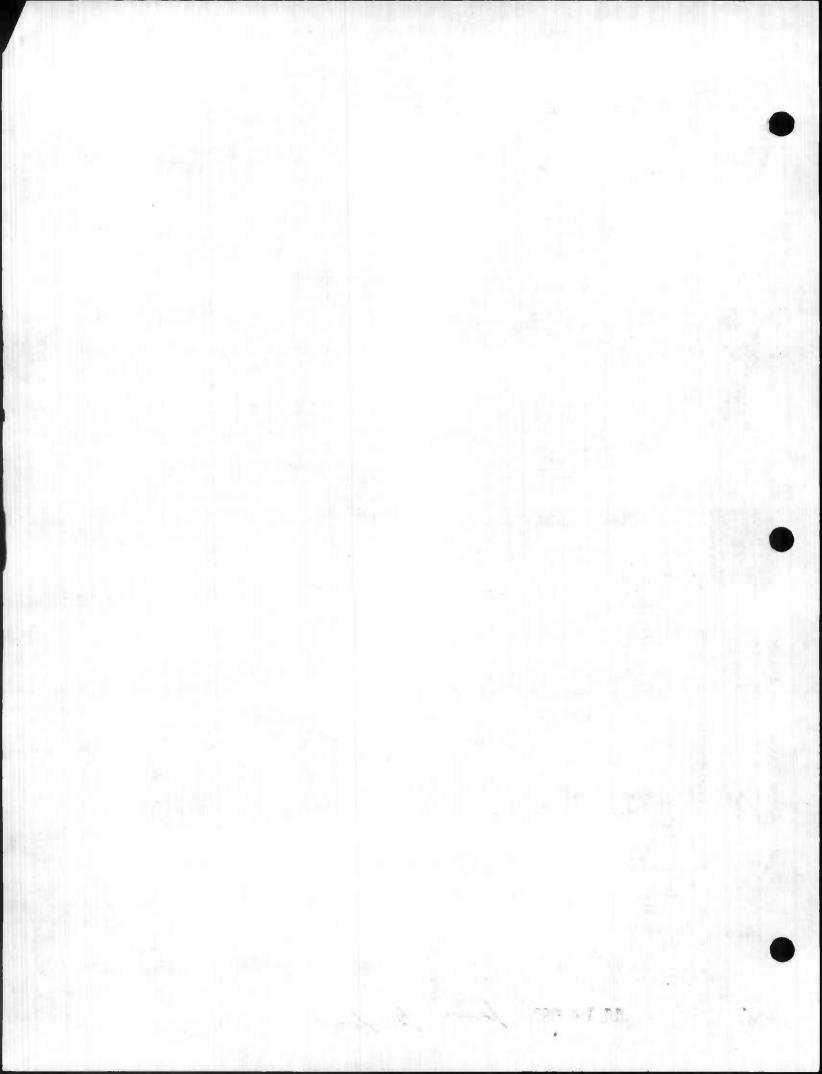
State Registrar

3

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Hospital

To the Hosp within 24 hou To the Fune completely fi



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State of Maryland / Department of Health and Mental Hyg

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100					Ce	rtificate d	of Death		Reg. No.	4	3000
Physiciar /Medica	Carl	me (First, Middla, Le	Joseph		Bech	ie		2. Dete of D	9, Dal 99	9 ^{Yaar}	3. Time of Death 10:30pm
Examine	4a Facility Nama	(If not Institution, given ny Count			me		4b. City, Town, Cumber				Legany
Funeral Director	5. Social Security 217-10	-4052	Sex 7.	Age (In yrs. Is 85		If Under 1 You Months Da		fin. 8. Dete of B. OCT 8	irth (ay, Year) 913	9. Birth Con	pplace (Stete or Foreign
death with the Maryland ms 23a or 28a-f show cross to noot so at	Usual Rasidance 10e. Stata MD	10b. County	gany	10c. City	Town or Lo	ocation mberla	nd				10d. Insida City Limit
unter death with the Ma in items 23s or 28s-1 or intermula mouther	10e. Street and N	old Lake	Drive	Bel A	ir	10f. Zip Coo	2150	2	10g. Citizen of USA	Whet Co	untry?
_ is 12	11. Maritel Stetus 1 Nevar Ma 3 Widowed	rrled 2 Married 4 Divorced	12. Wes Deceda Armed Forca 1 Yas 2 If Yas, Giva Yaar or Data	nt Evar in U,S No s:	6. 13.	Was Decedent If Yes, specify ((Specify Yes or N verto Ricen, atc.)		ce - Amar ck, White	
12 mil mil mil	(Sp	15. Decedant's E ecify only highest gra condary (0-12)	ducation ade completed) Collega (1-40	or 5+)	(Give		ccupation ona during most of tired)		16b. Kind of B		Industry
yland 21 vuid be filed wi Mental Hygian arked other th attic event, the	17. Fathar's Name	a (First, Middle, Last echie)			ou op		Nama (First, Middle (O'Gr	a, <i>Maid</i> an <i>Sum</i> an		
CENL	19a. informent's A. Mar	Name/Ralationship	Type, Print)		19b. Malli	ng Address (Sti	reet and Number of Lake Dr	Rural Routa Num ive; Cum	ber, City or Town, berland	State, Z	Ip Coda) ID 21502
Baltimore, Nemit. Pages 1 and Department of Health Important: If item 27 most. Indian 27 most.		isposition 2 Crametion 3 Crametion 5 Other (Special		Ita		osition (Nama o matory or other Memori		7/13/	20c. Location		
Baltim permit. Pag Department Important: I any injury o	21. Signature of I	Funeral Service Lice	1900 1 1 1 1 1	1000	21	Starpe	irespi FFWn	eral Ho aryland	me P.A		
Physician	23a. Pert I. Entai shock, or ha	rtha disaasa, or contaart failura. List o lly	oli ations that caus on a causa on aach	sa Tha deeth. n lina.	Do not an	ar the moda of	dying, such as car	diac or raspiratory	errast,		Approximata Intarval Batween Onset and Death
/Medical Examiner	Immediata Cause disaasa or condit rasulting in daath	ion	a. CORO	100	An-	TERY quance of):	DISE	455			10 9Ks
Box 68760, ath certificate be associed itending physician and for use as the bunel-transit	Sequentially list of if any, laading to ceusa. Entar Unc Causa. (Disaasa of that initiated evar rasulting In daath	conditions, immadiata derlying	b	Dua to (or	as a consad	quance of):	_				
Box 68760, ath certificate be an itending physician for use as the bune iten/Medical F	that initiated evar rasulting in death	tis) Last	d	Dua to (or	as e consec	juance of):					
Bo ath for u											1 - O. Car

by Physic

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown

MELLITUS

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 20 KNo

CONGESTIVE 25. Was case referred to medical examiner? 1 Yes 2 No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one) Other: 4 M Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify)

27. Mannar of Death 1 Natural 2 Accidant

3 Suicida

4 Homicida

28a. Data of Injury (Month, Day Year) 5 Pending invastigation 6 Could not be datarmined 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28b. Tima of 1 Yes 2 No

28d. Dascribe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifian (Check only one) 1 Certifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of cartifier

29c. Licensa number -14865

29d. Dete signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

ROBUSTIANO 31. Data filad (Month, Day, Mar) BHURER MD MEMORIAL HOST. CUMB. MO.

State Registrar

DHMH 16 Rev 6/95

To the Hospital or Attending Physicien: The law requires that the da

within 24 hours after death. To the Funeral Director: A

filled in by tha

completely

Division of Vital Records, P.O.

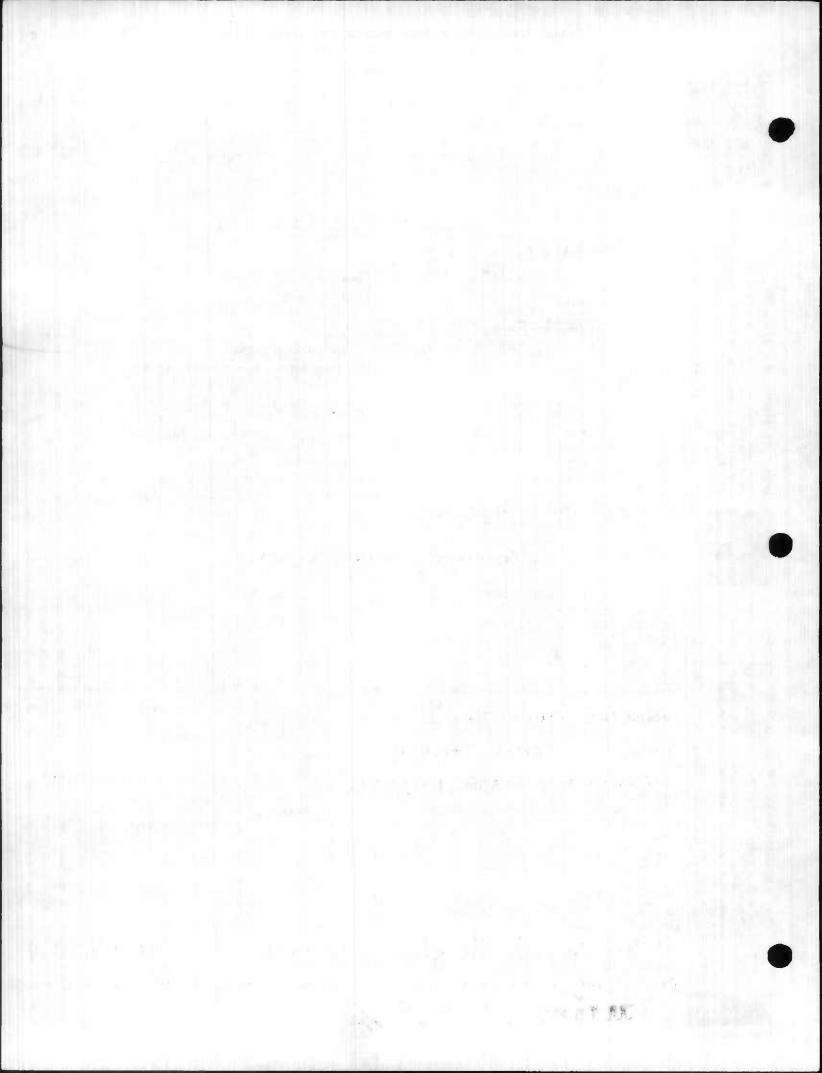
been signed by the should be detached

Completed

Be

Certification: To

Medicai



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q 23566

			Cer	tificate of	Death		Reg. No.	20000
	1. Decedent's Name (First, Middle, Las	t)				2. Date of	Death	3. Time of Death
Physician /Medical	Anna	Margaret	Broo	kman		Jul	10, 19	9'9° 07:14pm
Examiner	4a Facility Nema (If not institution, give Sacred Heart H	· ·				m, or Location of De	eath 4c. County	of Death Allegany
Funeral Director	213 30 0730	7. Age (In yrs.		Months Deys	Hours Hours	4 Hrs. 8. Date of Min. Jan	Birth Year 902	Birthplace (State or Foreign County) D
ms 23s or 28s-f show country be notified at neral Director	Usual Residence of Decedent 10a, State 10b, County	10c Cit	y, Town or Lo	cation				10d. Inside City Limits
Sa-f short	MD Alle			mberlan	d			1 ☐ Yes 2 ☐ No
r items 23s or 23s-f si nost must be notified Funeral Director	10a. Street and Number 11909 Iris Ave	nue		10f. Zip Code	215	02	10g. Citizen of V USA	Vhat Country?
if item 27 is marked other than "natural", or items 23s or 28s-f show or other traumstic event, the Medical Examinar must be notified at or other traumstic event, the Medical Examinar must be notified at or other traumstic event, the Medical Examinar must be notified at or other traumstic events.	11. Marital Status 1 Never Married 2 Merried 3X Widowed 4 Divorced	12. Wes Decedent Ever in U. Armed Forces? 1	H	Wes Decedent of H I Yes, specify Cub I □ Yes 2 No	tispanic Origi an, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	Blac	e - American Indian, sk, White, etc.
De la	15. Decedent's Edu	ucation	16a. Deced	ient's Usual Occup	pation		16b. Kind of Bu	usiness/Industry
rt, the Medical I	(Specify only highest grad	le completed) College (1-4or 5+)	life. L	kind of work done DO NOT use retire maker	during most of d)	of working	own ho	me
To Be C	17. Father's Neme (First, Middle, Last) Jacob Hausman					's Neme (First, Mide R (Ha	dle, Maiden Surnari ndel)	(9)
	19a. Informant's Name/Relationship (T Joseph E. Broo		19b. Mailin 1190	9 Iris	and Number Avenu	or Rural Route Nu e ; Cumbe	rland,	Stere, Zip Code) MD 21502
any injury or other tr	20a. Method of Disposition 1 Deurial 2 Cremation 3 1		Place of Dispo- cametery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location -	City or Town, State
	4 □ Donation 5 □ Other (Specify,		Pete	r & Pau	1 Cem	ete7/14	/ Cumbe:	rland, MD
DUCE.	21. Signature of Funeral Service Licens	M A . 00()					ome P.A	
	23a. Part 1. Enter the disease, or comp	J. XIIIIIII				Marylan		Approximate
cian dical hiner	shock, or heart tailure. List only of Immediate Cause (Finel disease or condition resulting in death)	· Acute	My or as a conseq	OCANDI wence of):	al g	farct	ion	triterval Between Onset and Death
for use es the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (a	r as a conseq	uence of):				
3	that initieted events resulting in death) Last	Due to (o	res a consequ	uence of):				
detached for use	Part It. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying cause giv	ven in Part I.	-	/	ntribute to the cause of death?
be det							☐ Yes 2½/No	5 Froming 4 Onkion
2 should						24a. W	as an autopsy enformed?	24b. Were autopsy findings available prior to completion of cause of death?
Con						1	Yes 2 No	1 ☐ Yes 2 ☐ No
800	25. Was case reterred to medical axaminer?	Hospitel:	_/	0		of Deeth (Check on	ly one)	
To To	1 Yes 2 No	1 □ Inpatient 2 □	ER/Outpatien	3LI DOA			esidence 6 Oth	
Certification:	2/. Menner etn 1 etural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury	M 1	ryant rk? IYes 2∐N	lo	be how injury occur	2 2000
Certifi	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, ferm, stri y)	eet, lactory, office		28f. Locatio City or	n (Street and Numb Town, Stete)	er or Rural Route Number,
edical	29a. Cartifier (Check only one) 1 ☐ Cartifying Phy 2 ☐ Medical Examl	alcian: To the best of my knowner: On the basis of examiner and menner stated.	wledge, death tion and/or inv	occurred at the tirestigation, in my o	me, date and opinion, death	place, and due to to n occurred at the tin	he cause(s) and ma ne, date and place,	anner as stated. and due to the cause(s)
	29b. Signature and title of certifier	agen on M	0	29c. Licens	se number	2181	29d. Dete signe	d (Month, Day, Year)
F3	30. Name and address of person who co			Print) Sh Driv	e Cum	berland	MD 215	02
State egistrar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	,				
6 Ray 6/95	JUL 1 3 199	14 France	Ø.	Apol	0.41			

DHMH 16 Ray 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** Bernard Cole 1999 JULY 15 2:10 P.M. /Medical 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) Apr 22, 1928 ff Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2□ F MD 234-40-3392 71 Director Uaual Residence of Decedent the Manyland 10a State 10c. City. Town or Location 10b County 10d, Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumstic avent, the Hedical Examiner must be notified at 1 Yas 2 No Director MD Allegany Cumberland 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 208 Seymour Street USA Funeral death 12. Was Decedent Ever in U.S. Aumed Forces? ★ Yes 2 □ No If Yes, Give Yeer or DetesKorea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Introcrant: If Nam 27 is marked other than "natural", or her any Injury or other traumatic aware. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□No Specify: Specify: white py 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retired Mechanic Housing Authority 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Wolfe) Harry Edgar Cole Mary C 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
208 Seymour Street; Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) Donald W. Cole 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 7/19/ Cumberland, MD 21. Signature of Funeral Service Licenses 25 Carbers Fruneral Home P.A. Cumberland, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting In deeth) /Medical Acute Myocardial Infarction 1 day Examiner Due to (or as a consequence of): Examiner burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): pue physician street Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): been signed by the attending should be detached for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Colon cancer with metastasis þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy Chronic obstructive pulmonary disease 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate luneral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ⊅ No Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 5 Pending investigation Natural 2 Accident 1 Yes 2 No death. or Attendation of the or Attendation of the or Attendation of the order of the orde 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29e. Certifier Medical (Check only one) niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29b. Signeture end title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) JULY /\$,1999 D33280 3 30. Name and address of person who completed cause of death (item 23a) (Type, Print) DR.GUPTA JOHNSON HEIGHTS BLDG. 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD 21502 31. Dete filed (Month, Day, Year) 32. Registrar'a Signature State

DHMH 16 Rev 6/95

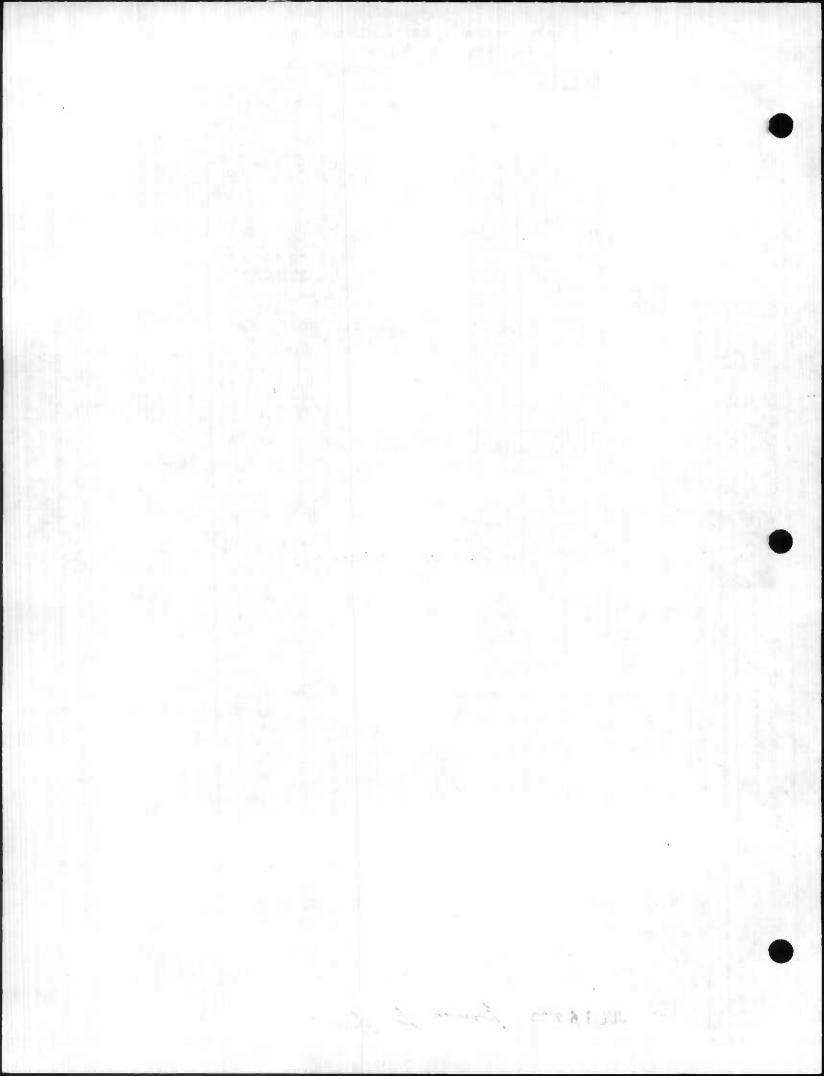
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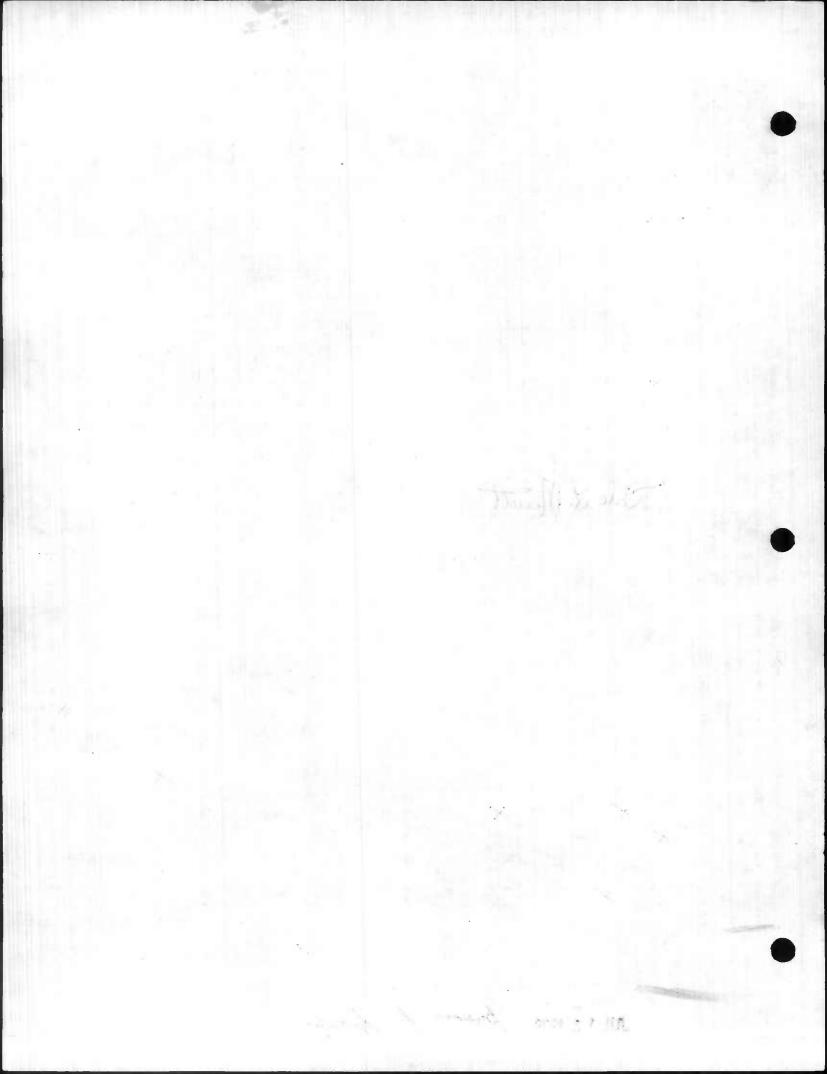
214-07-0161

JOHN CHISHOLM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

an	Decedent's Name (First, Middle,	I act)		Cei	timouto t	of Death	2 Det	Reg.	No.	- Annap	3 6 6 8
- 61	JOHN FREEMAN	CHISHOLM	SR.				Jul	nth	Day 1999	Year	4:20 am
al er	4s Fscility Name (If not institution,	give street and numbe	or)			4b. City, Tov	vn, or Location of	-	4c. County of	of Death	4.20 am
	Memorial Hospi	tal.				Cumbe	rland,		Alleg	anv	
	5. Social Security Number 6	5. Sex 7. / 1√□ M 2□ F	Age (In yrs. la 91	ast birthday) Yrs.	If Under 1 You Months De		Min. 8. Date Min. (Mo	of Birth nth, Day, Ye	ar)		lace (Stata or Foraign try)
ı	214-07-0161 Usuat Residence of Decedent	A	71	Trs.			\$EPT	29 19	07 M	ARYL	AND
	10a. State 10b. County		10c. City	, Town or Lo	cation					t	Od. Inside City Limits
	MARYLAND ALLEG	ANY		CUMBER	LAND						1 ☐ Yes 2 No
ı	10e. Street and Number				10f. Zip Cod	e		10g.	Citizen of W	hat Coun	try?
	13214 FRANTZ HOL	LOW ROAD N		2 12 1	215		in? /Snacity Va	e or No-	U.S.		an Indian,
	1 ☐ Never Married 2 ☐ Married	Armed Forces	\$?		0.1		in? (Specify Ye , Puerto Rican, e	etc.)	Black	, White,	etc.
	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		I□Yes 2█	No Specify:			Specify:	WHI	TE
	15. Decedent's (Specify only highast	Education grada completed)	ur/ ² ls/	(Giva	lent's Usual Oc kind of work do	ne durina most	of working	16b	. Kind of Bus	siness/inc	lustry
	Elementary/Secondary (0-12)	College (1-4o	r 5+)		SPRTNG	tired) FIELD TI	RE CO.	т	IRE MA	NIIF	
	17. Father's Name (First, Middla, La	est)	,		2111101		's Name (First,				H. T. C.
	JOHN FREEMAN CH	HISHOLM					MARGARE				
	19a. Informant's Name/Relationship	p (Type, Print)	LE-T	19b. Mailin	g Address (St	eet and Number	r or Rural Route	Number, Ci	ty or Town, S	Stata, Zip	Code 502
	JOHN F. CHISHOLM	I JR.	SON		FRANT2		ROAD N				MARYLAND
	20a. Method of Disposition 12 Burlal 2 □ Cremation 3	Removal from Stat	Ce	matary, cren	matory or other	place)	Date		Location - (
	4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		SOM			JULI dress of Facility	15 1999	Cui	MBEKLA	ND M	ARYLAND
1	900	M	2				JNERAL H	IOME P	. A.		
ł	23a. Part1. Enter the disease, or co	omp ations that cause	ed the death.	Do not ente	4 DECAT	TIR STRE	ET CLME	ERLANI atory arrest,	MARY	LAND	Approximate
١	shock, or heart failure. List or	nly one cause on each	line.								tritarval Between Onset and Death
ı	Immediate Cause (Final diseasa or condition	Corona	ry Art	ery D	isease						10 years
İ	resulting in death)		Dua to (or	as a conseq	uence of):					1	
ı		b	Due to for	as a conseq	140000 off:						
	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying		D00 10 (01	as a conseq	berice or).						
ĺ	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or	as a conseq	uence of):						
		d									
	Dad to Other steeldless to an elitera		h. 1 1	h' 4 45		of and Bank	1 00	h Bidasha		1	M
	Part II. Other significant conditions	Sommouning to death	JUL HOL FOSU	rang in the U	wenying cause	प्राप्ता ॥ १४त ।	23	1 Yes			the cause of death?
							24	a. Was an a		av	ere autopsy findings allable prior to appletion of cause
										of	death?
									1		714 00714
	25 Was pass reloyed to medical							1 Ves	200	11.]Yes 2□ No
	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital:	tient 2 🗆 F	R/Outnation	t 3ELDOA	Other	of Death (Checasing Home 5	-	6 DOthe		
	examiner? 1 Yes 20 No 27. Manner of Death	28a. Date of In	iury	ER/Outpatien 28b. Time of thiury		Other: 4 Nur	rsing Home 51	Rasidence	6 Othe	r (Specif	
	examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of In (Month, D	iury		28c. l	Other	rsing Home 51 28d. De	Rasidence scribe how i	njury occurre	r (Specif	1)
	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of tnjury	28c. I	Other: 4 Nur njury at Nork? I Yes 2 1	28d. De 28f. Loc	Rasidence scribe how i	njury occurre	r (Specif	
	examiner? Yes No	28a. Date of In (Month, D ton t be ed 28e. Place of I building, t	njury - At hor	28b. Time of tnjury me, farm, str	M Meet, factory, off	Other: 4 Nur niury at Work? I Ves 2 N	28d. De 28f. Loc	Rasidence scribe how in action (Street or Town, Street	njury occurre t and Numbe tate)	r (Specif ed er or Rurs	r) I Routa Number,
	examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could no determine 29a. Certifier Certifying	28a. Date of In (Month, D	njury - At hor etc. (Specify) at of my know of examinati	28b. Time of tnjury me, farm, stn	28c. (M set, factory, off	Other: 4 Nur njury at Work? I Ves 2 N ce	28d. De 28d. Loc City	Rasidence scribe how in station (Street or Town, Street or Tow	njury occurre	r (Specified	() I Route Number,
	examiner? 1 Yes No 27. Manner of Death 1. Natural 5 Pending investigat 2 Accident 6 Could no determine 29a. Certifier Check only 2 Medical Ex	28a. Date of In (Month, E) 28a. Place of I building, (28b. Place of I building, (28c	njury - At hor etc. (Specify) at of my know of examinati	28b. Time of tnjury me, farm, stn	28c. I M set, factory, off	Other: 4 Nur njury at Work? I Ves 2 N ce	28d. De 28d. Loc City	Rasidence scribe how in ation (Street or Town, Street or the cause a time, date	t and Number (and Number (and place, and place, a	or (Specified or or Rura mor as 8 mod due to	I Routa Number, ated. the cause(s)
	examiner? 1	28a. Date of In (Month, E) 28a. Place of I building, (28b. Place of I building, (28c	njury - At hor etc. (Specify) at of my know of examinati	28b. Time of tnjury me, farm, stn	M set, factory, off	Other: 4 Num njury at Work? I Ves 2 N ce	28d. De 28d. Loc City	Rasidence scribe how in ation (Street or Town, Street or the cause a time, date	t and Number (ata) (ata) (b) and mar and place, a	or (Specified or or Rura mor as 8 mod due to	I Routa Number, ated. the cause(s)
	examiner? 1 Yes No 27. Manner of Death 1. Natural 2 Accident 3 Suicide 6 Could no determine 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address purson with	28a. Date of In (Month, D) 28a. Place of It building, 6 28b. Place of It b	njury - At hor etc. (Specify, et of my unow of examinational stated.)	28b. Time of Injury me, farm, stri modge, death on and/or inv	28c. I	Other: 4 Nur njury at Work? Ves 2 N ce stime, date and ny opinion, deat	28d. De 28f. Loc City place, and true h occurred at th	Rasidence scribe how in ation (Street or Town, Street or the cause a time, date	t and Number (and Number (and place, and place, a	or (Specified or or Rura mor as 8 mod due to	I Routa Number, ated. the cause(s)
	examiner? 1 Yes No 27. Manner of Death 1. Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of In (Month, D) too 28e. Place of In building, of Physician: To the best arminer: On the basis and manner so occumpleted cause of	njury - At hor etc. (Specify, et of my unow of examinational stated.)	28b. Time of trijury me, farm, stri medge, death on and/or inv 23a) (Type, l	28c. I	Other: 4 Nurnipury at Nork? Ves 2 Nork? ce stime, date and y opinion, death ense number 36766	28d. De 28d. Loc City	Rasidence scribe how in ation (Street or Town, Street or the cause a time, date	t and Number (and Number (and place, and place, a	or (Specified or or Rura mor as 8 mod due to	I Routa Number, ated. the cause(s)

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Effie Elizabeth Glass 15, 1999 4c. County of Death 1999 2325 p.m JULY /Medical 4e Facility Neme (tf not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Sacred Heart Hospital Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 200 F Months Yrs. 217-80-5168 Director 18-Oct-16 Maryland Usual Residence of Decedent r 28a-f ahow 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 No 2 No Director Maryland Allegany Frostburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ma 23a or 2 With 21 Centennial Street 21532death Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. r than "natural", or items the Medical Examiner m 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item only Injury or other traumatic event, the Medical Emirical Pages. 1 Yes 200 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married altimore. Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 homemaker 8 homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be 2 Harry Margroff Sarah Beckett 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Glass 83 Victoria Lane Frostburg Maryland 21532-20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Saint Paul's Lutheran Cemetery 18-Jul-99 Accident, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Physician Severe Bill Cerebral Infarth in
Due to (or as a consequence of): /Medical Immediete Cause (Finai disease or condition resulting in death) Examiner Examiner **burial-transit** The lew requires that the death certificate be executed pue Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the Due to (or as e consequence of): for use es Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 100 3 Probably 4 Unknown Records, þ 8 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autoosy runner Taumker Atrial forwardin 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate History of Vital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yas 2 No 1 Phopatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation Natural 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide pelli Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner atated. 29a, Certifier To the I within 2 To the I 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier n 921244 7-16-99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Jesus Tan, M.D., Frostburg Plaza, Frostburg, Maryland 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar

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217-80-3168 Ph. 128 Metricular

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Harry Margrott Satern Beckelt .

Jalin A. Jalin S. John Meine Baret 201 June Frostburg Meineur II 2 25

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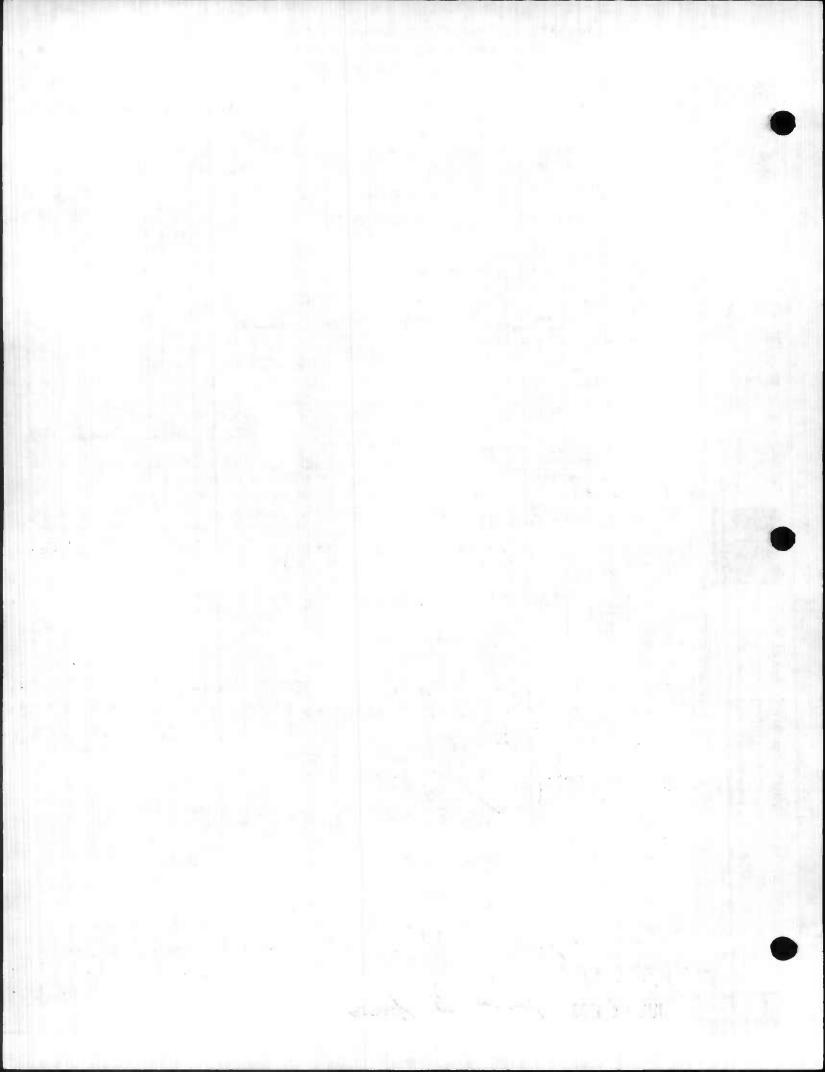
Durst Funeral Home, 57 Frost Avice troubling with 21 and

morning them the three

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** David Charles Hallenbeck July 13 1999 7:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sacred Heart Hospital Cumberland Allegany If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Aug 22, 1940 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Deys Hours 15 M 2□ F 055-34-5551 58 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f ahow 1 Yes 2 □ No Director Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 59 W. Main Street 21532 USA Nerns 23a death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 Yes 2 40 If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 "natural", or 1□ Yes 2□No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Field Engineer NASA Satellite Tracking permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked obth any injury or other treumatic event abdata. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Hallenbeck Dorothy (nmn) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 W. Main Street; Frostburg MD 21532 19a. Informant's Name/Relationship (Type, Print)
Sonia F. de Hallenbeck 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory: 7/17/ Cumberland, MD 21. Signature of Funeral Service Licensee 25carper 1 Funeral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last e to (or as a consequenca of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 080 23b. Did tobacco use contribute to the cause of death? Other aignificant conditions contributing to death but not resulting in the underlying cause given in +Task 3 Probably 4 ☐ Unknown 1 ☐ Yaa 2 ☐ No signed b þ 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed completion of cause of death? mas 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Vas case referred to medicat examiner? 26. Placa of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this After thi funeral 27. Manne of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. tnjury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of ceptifier? 10 path (tem 23a) (Type, Print) Cumber 1) tive YND 215 67 32. Registrar's Signature JUL 1 9 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middla, Last)

Humbertson Beulah

Jul 10,

2 Data of Death

3 Time of Death 02:05am

4a Facility Nama (If not institution, giva street and number) Allegany County Nursing Home

4b. City, Town, or Location of Death Cumberland

4c. County of Deeth Allegany

Funeral Director

death with the Maryland ir than "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at Directo Funeral permit. Pagas 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examine page. by Completed

1□ M 2 F

7. Aga (In yrs. last birthday) | ff Undar 1 Yaer | If Undar 24 Hrs. | 8. Dete of Birth | 7. Aga (In yrs. last birthday) | Months | Deys | Hours | Min. | Apr 1, 1920

Birthplaca (Stata or Foraign County)

Usual Rasidance of Decedent 10a, Stata 10b. County

216-72-6274

Allegany

Oldtown

10d. Insida City Limits

10e. Street and Number

10c. City, Town or Location

1 Yes X No

17304 Oliver Beltz Road SE

21555

10f. Zip Coda

1 ☐ Yes 🌪 ☐ No

10g. Citizen of Whet Country? USA

Day 1999 ar

1 ☐ Never Married 2 ☐ Married ₩ Widowed 4 Divorced

12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Yeer or Detes:

Was Decedent of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuben, Maxican, Puerto Rican, etc.)

14. Race - Amarican Indien, Bleck, White, etc. Specify: white

15. Dacadant's Education (Specify only highest grade completed)

18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) Collega (1-4or 5+)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

homemaker

own home

17. Father's Nama (First, Middle, Last)

Frank Bennett

18. Mothar's Nema (First, Middle, Maidan Surname) Gustavia (Ketterman)

19a. Intormant'a Name/Ralationship (Type, Print)
Ruth A. Youngblood

20b. Placa of Disposition (Nama of cemetery, cramatory or other place)

19b. Melling Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) 17304 Oliver Beltz R; Oldtown, MD 21555

20c. Location - City or Town, State

daughter
20a. Method of Disposition

1 Burial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Glendale Cemetery

7/12/ Flintstone, MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each limit.

25 Carper Fruneral Home P.A. Cumberland, Maryland 21502

Physician /Medicai Examiner

attending physician and for use as the burial-transit

signed by the a

been sig

cartificata has b

this funeral

After !

within 24 hours after death To the Funeral Director: / completely filled In by the

death.

The law requires that the death certificate be executed

or Attanding Physician:

the Hospital

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

þ

Completed

Be

0

Certification:

edicai

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disassa or injury that initiated evants rasulting in death) Last

immediata Causa (Final disaase or condition rasulting In death)

. CARCINOMA OF THE Dua to (or as a consequence ot):

Due to (or as a consequence ot): Dua to (or as a consequence ot):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the caues of death? 1 Yee 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performad?

24b. Were autopsy findings available prior to completion of cause of death?

Approximete Intarval Between Onsat and Death

TUS

1 ☐ Yas 2 ☑ No

26. Placa of Deeth (Check only ona)

1 ☐ Yas 20XNo

25. Was casa ratarred to medical exeminer? 1 ☐ Yas 2 No

> 5 Panding Invastigation 6 Could not be determined

Hospitel: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of

28a. Placa of Injury - At home, farm, straet, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Yas 2 No

Other: 4 Mursing Homa 5 ☐ Rasidance 8 ☐ Other (Specify) 28d. Dascribe how injury occurred

MU.

29a. Certifiar (Check only one)

27. Mannar ot Death

1 Neturel 2 Accident

3 Suicide

4 ☐ Homicida

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and manner steted.

29b. Signeture and title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

28t. Location (Street and Number or Rural Routa Number, City or Town, Stata)

woo

cu

21502

30. Nama and eddress of person who completed cause of deeth (Item 23a) (Type, Print) BARNENA

KOBUS MANO 31. Data tiled (Month, Day, Year) JUL 1 3 1999

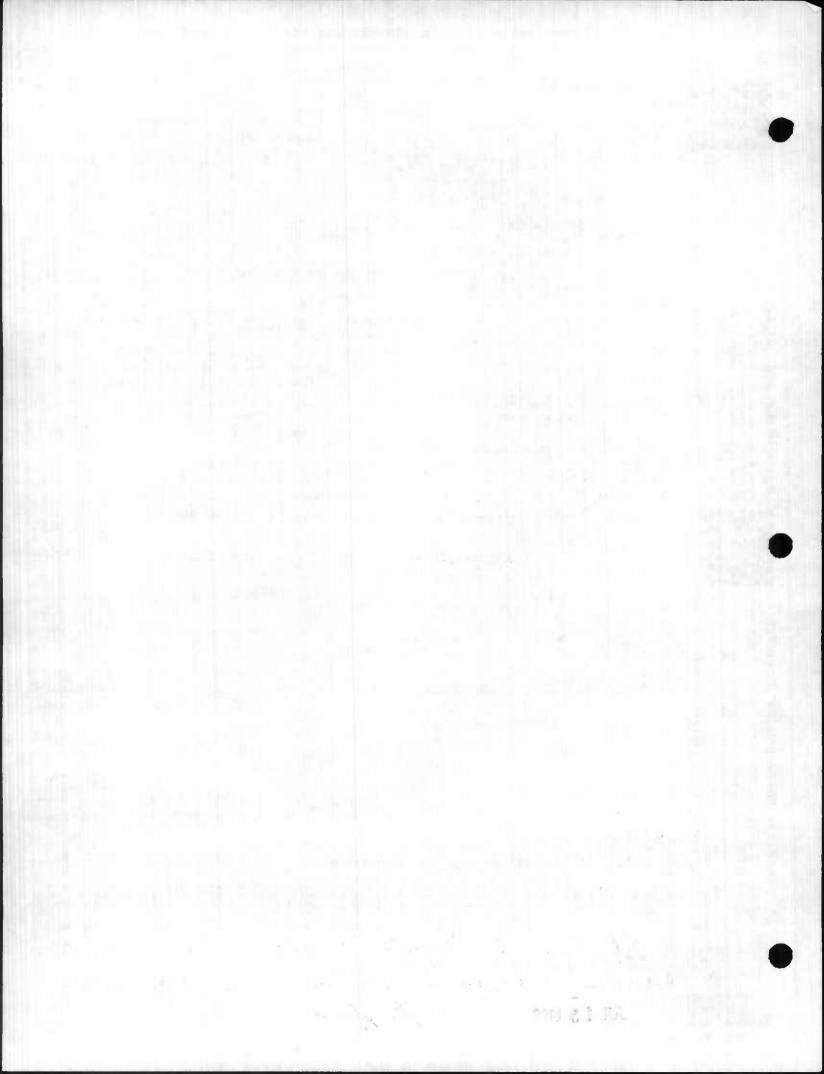
32. Registrer's Signeture

HOSP. CUMB. MEM.

State Registrar

6

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Salem Ronald Humbertson July 15,1999 0100 am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
Mar 18, 1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 GM 2 □ F Yrs. 213-40-2851 57 Director Uaual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yas 2 No Director MD Allegany Cresaptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14808 Vermont Avenue 21502 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces?_ 14. Race - American Indian, 11 Meritel Status Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or he may injury or other traumetic event, the Medical Examine pages. 1 Yes 2 No
If Yes, Give
Year or Detea: 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1□ Yes 2□ No Specify: Specify: white à 3 ☐ Widowed 4 🏋 Divorced Completed 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Times-News Former Employee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salem Humbertson Mary (Swach) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20305 Kelly's Lane; Hagerstown MD 21 Dawn-Yvette Mitchell MD 21742 20a Maring of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 7/19/ Cumberland, MD 21. Signeture of Funeral Service License "ScarperTI Funeral Home P.A. Cumberland, Maryland 23a. Part 1. En er the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Metastatic 1 year disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacce use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 3 signed l mypercalcemis Records, by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peeu memia completion of cause of death? 1□ Yas 2□Ho 1 ☐ Yes 2 DINO Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica compliately filled in by the funeral director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner Deth 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation 1 Mitural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier my 252056 comedical poctor) July 15 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 Albert C. VILI amsa consu Nosal Cumber 1 and 925 Bishop 32 Registrar's Signature

DHMH 16 Rav 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 6 1999

ACE 18 1200 - 1- --

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie Certificate of Death

If Under 1 Year

Months

ne	Q	0	2	2	6	7	
	1	2	C.,	U	U	-	

Allegany
9. Birthplace (State or Foreign

Pennsylvania

Year

1999

4c. County of Deeth

3. Time of Deeth

6:45A.M.

10d. Inside City Limits 1 Yes 2 No

	1. Decedent's Nar	me (First, Middle, La	st)			
Physician /Medical	Clarence William He					
Examiner	4a Facility Name	(If not institution, give	0 5			
	Memorial	Hospital	8			
Funeral Director	5. Social Security 181–18–8	Number 8. S	ex			
77	Usual Residence	of Decedent				
yland	10a. Stete	10b. County				

death with the Ma

ir than "natural", or items 23s or 28s-1

permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or then any injury or other traumatic event, the Medical Examina

Physician /Medical

Examiner

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After Attending

death.

after death Director:

To the Hospital
within 24 hours a
To the Funeral C
completely filled hours a Hospital

Examiner

Physician/Medical

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Completed

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Certification:

edical

Saltimore, Maryland 21215-0020

Funeral

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Completed

Be

Clarence William Hengst, Sr 4a Facility Name (If not institution, give street and number) <u> Memorial Hospital & Medical Center</u> 1 M 2□ F 181-18-8823 Usual Residence of Decedent 10a. Stete 10b. County Bedford Pennsylvania

10c. City, Town or Location Hyndman

7. Age (In yrs. last birthday)

78

12. Wes Decedent Ever in U.S. Armed Forces?

10g. Citizen of What Country? 10f. Zip Code 15545

2. Date of Death

July 11,

8. Dete of Birth May 23, Yeard 21

Month

4b. City, Town, or Location of Death

Cumberland

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

United States 14. Race - American Indien, Bleck, White, etc. Specify: White

Armed Forces? 1942-1946
1 Mayes 2 No
If Yes, Give
Year or Detes: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (154or 5+)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) Chemist

1d Yes 2 No Specify:

16b. Kind of Business/Industry Celanese

17. Fether's Neme (First, Middle, Last) John W. Hengst

202 Clarence Street

1 Never Merried 2 Merried

10e, Street and Number

11. Merital Stetus

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rella Divley

18. Mother's Neme (First, Middle, Maiden Sumame)

Clarence Hengst/Son 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State

19a. Informant's Name/Relationship (Type, Print)

202 Clarence Street Hyndman, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place)

Hyndman Cemetery

20c. Location - City or Town, Stata July 14, 1999 Hyndman, Pennsylvania

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

arlasta 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.

Harvey Zeigler Funeral Home Hyndman, Pennsylvania Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth)

MUTIPLE MYELOMA

Due to (or as a consequence of)

Due to (or as a consequence of).

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last

Due to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

CHRONIC RENAL FAILURE

23h. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

2 N No

1 ☐ Yes 2 1 No

25. Was case referred to medical 1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

29e. Certifier (Check only 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier (Janesa

D_14865

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEMORIAL HOSPITAL MEDICAL BUILDING, CUMBERLAND, MD DR BARRERA 31. Date filed (Month, Day, Year)

21502

n State

Registrar

32. Req strar's Signature

DHMH 16 Ray 6/95

Box 68760 181-18-8823

P.O. Records. CLARENCE HENGST Division of Vital

A TOP A TIME

Physician /Medical Examiner

Funeral

Director with the Manyland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at filed within 72 hours after

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien important: if them 27 is marked other than any Injury or other transments.

0 - 7013

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DOROTHY JHONSON

Physician /Medical Examiner

the burial-transi certificate be asseut and USB BS signed by the 8 peen certificata

Box 68760. Records, Division of Vital To the Hospital or Attanding Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completely

Physician/Medical þ Be Completed 2 Certification: edical

10a. Stata VA Director 10e Street and Number Funeral p Completed 12 Be 20a. Mathod of Disposition Immediata Causa (Final disaasa or conditio rasulting in daath)

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 12 Pay DOROTHY FAY TIMOath **JOHNSON** 1999 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Sept. 3, 1912 9. Birthplace (State or Foreign Days 10 M 20 F Months Hours WEST VIRGINIA 86 217-10-7013 Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits WARREN FRONT ROYAL 10f. Zin Code 10g, Citizen of What Country? 2729 RIVERMONT DRIVE 22630 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No Specify: WHITE Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) DENNIS HOWARD SPRINGER LITLIA DAY 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 2729 RIVERMONT DRIVE, FRONT ROYAL, VA BARBARA HARPER / DAUGHTER 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) M.S.V.C.-ROCKY GAP 7/15/99 FLINTSTONE, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 23a. Part 1. Enter the disease, or complex tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death COPD 2 Years Due to (or as a consequence of) Sequentially list conditions, if any, laading to immediala cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as e consequence of): Dua to (or as a consequence of):

Part II. Other eignificant conditions of ASHD	ontributing to death but not re-	sulting in the underlying	g causa given in Part I.	23b. Did tobacco uee co	ontribute to the cause of death
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical			26. Place of D	Death (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 125Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Homa 5 ☐ Rasidence 6 ☐ Ott	har (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accidant invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work?	28d. Describe how Injury occur	rred
3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	oma, ferm, street, fact	ory, office	28f. Location (Street and Num	ber or Rural Routa Number,

building, atc. (Specify)

City or Town, Stata)

JULY 125, 1999

11:50 a.m.

1 Yas 2 No

29b. Signature and title of certifier

4 Homicida

29a. Certifier

Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and piace, and dua to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, end dua to the cause(s) end manner stated. 29d. Data signed (Month, Day, Year) 29c. License number

30. Nama and eddrass of person who completed causa of death (Item 23a) (Type, Print)

DR. BARRERA, MEMORIAL MEDICAL BUILDING, 500 MEMORIAL AVENUE, CUMBERLAND, MD 21502

State Registrar

a

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31. Data filed (Month, Day, Year) JUL 16

32. Registrar'a Signatura

Sport

D14865

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 23675 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician RUTH MAE LEWIS JUL 17, 1999 3: 17 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 245 E OFFUTT STREET CUMBERLAND ALLEGANY If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Dete of Birth (Month, Day, Year) **Funeral** Months Days Min. Hours 1 M 2 F Director 214-74-9741 Jun 17, 1910 Usual Residence of Deceden the Meryland 10a. State 10b. Counts 10c. City. Town or Location **ehow** 10d. Inside City Limits 1√ Yes 2 No Director 288-7 Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 death with Items 23s 245 E Offutt Street 21502 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. filed within 72 hours after thygiene. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 "natural", or 1 Yes 2♥ No Specify: 20 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Heelth and Mantal Hyglern Important: if item 27 ie marked other the any injury or other treumatic event, that phose. 12 homemaker own home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 James Robert Howdershell Nora Wolfe 19a. Informant's Name/Relettonship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Geraldine Taylor-daughter 251 E. Offutt Street; Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 07/20 Cumberland, MD 21502 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one if use on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical attendente Concern Examiner Due to (or as a consequence of): Examiner thereby ician end burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician e Box 68760. Physician/Medical Due to (or as a consequence of): for use es Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? o ۵ Decarti mulipa 1 Yes 2 No 3 Probably 4 Unknown Records. þ P S 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1□ Yes 2□No 1 Tyes 2 No Division of Vital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home - Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending Natural 1 Yes 2 No death. investigation n 24 hours efter death ie Funeral Director: A pietaly filied in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier Medical within 24 hor To the Fune completely fi (Check only one) To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) fellow m N JUL . 19, 1999 D17565 DR. ANTHONY BOLLINO, MD; 922 NATIONAL HWY; LAVALE, MD 21502 Me

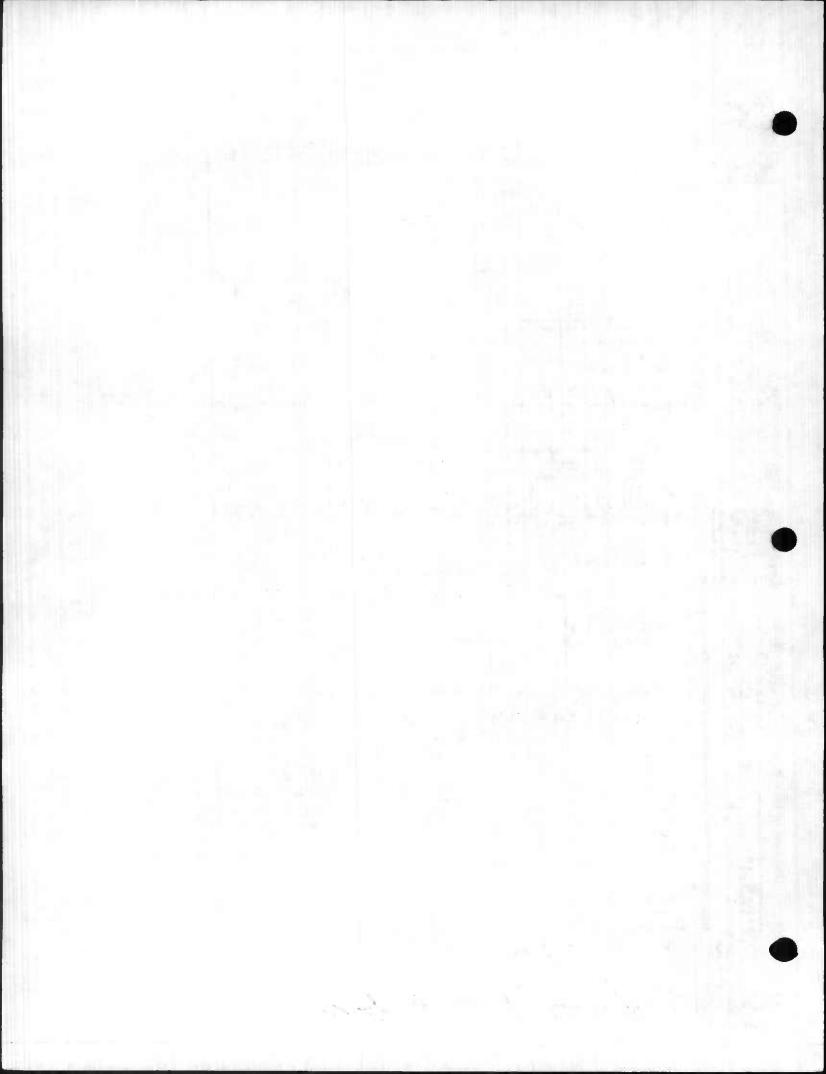
DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

JUL 1 9 1999



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** LaRae ADA MILLER JULY 11, 1999 :55 A.M. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick Months Days Hours Min December 3, 1931 9. Birthplaca (State or Foreign Country) Pennsylvania 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months 196-22-6038 67 Yrs. **Director** Usual Rasidance of Decedant permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if them 27 is marked other than "naturel", or thems 23a or 28a-f show eny injury or other traumatic event, the Medical Exercises. 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Vas 2□No Maryland Frederick Directo Frederick 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21701 800 Motter Avenue, Apartment 113 United States Funeral 14. Race - Amarican Indian, Bleck, White, atc. 12. Wes Decedent Ever In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 ☐ Nevar Merried 2 Малгied 1 ☐ Yas 2 ☐ No If Yas, Giva Yaer or Datas: Specify:White 1 ☐ Yas 2 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Seamstress Textile 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Howard Lasure Rose Bittinger 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Motter Ave, Apt 113 Frederick, Mayrland Melvin Miller - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition 1 ☑ Burial 2 ☐ Crametion 3 ☐ Removal from State Pine Hill Cemetery July 13, 1999 Berlin, Pennsylvania 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture of Funarel Sarvice Licansee 22. Neme end Address of Fecility Harvey H. Zeigler Funeral Home 23a. Pent. Entar the disaese, or complications that clused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on a ch line. J. Pettique Approximata Intervel Between Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting In death) /Medical Jepsis Examiner Dua to (or as a consequance of): Examiner Hyperkalemia physicien and the burial-transit requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disaase or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, ra Physician/Medical Dua to (or as a consaquance of): 98 Melliti USB signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Artery Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 s has certificate T Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Placa of Death | Check only one Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 ☐ Yes 2 No 10 this funeral 27. Manner of Death 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: or Attending Natural 5 Panding Hospital or Attending 124 hours efter death.
 Funeral Director: After 1 T Yes 2 No Invastigation 2 Accidant 6 Could not be determined 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide filled In by 4 Homicida Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar es stated.

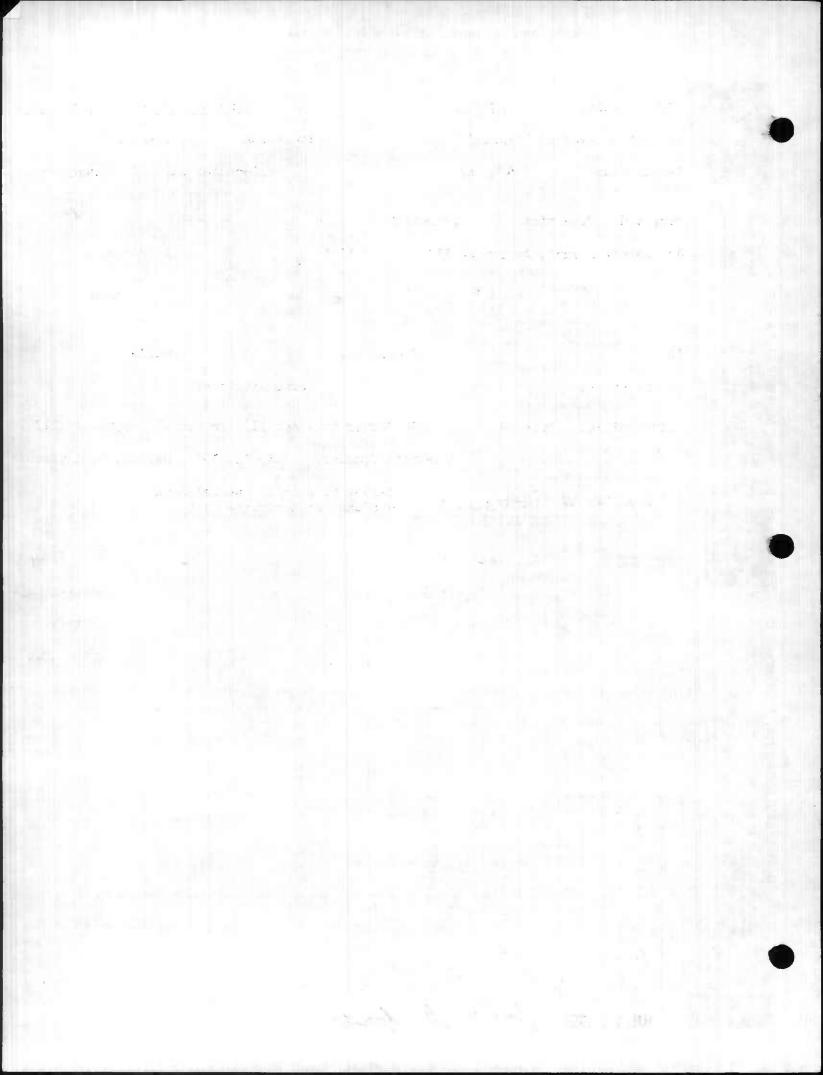
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifiar Medical (Check only one) within 2 29b. Signeture end title of certifier 29d. Data signad (Month, Day, Year) 29c. License number 6 30. Nama and address of person who completed ceusa of daath (Itam 23a) (Type, Print) Thomas Dr. Mis 56 Johnson Amydones MD 31. Data filed (Month, Day, Year)

State Registrar

JUL 1 9 1999

32. Registrar's Signatura

DHMH 16 Rev 6/95

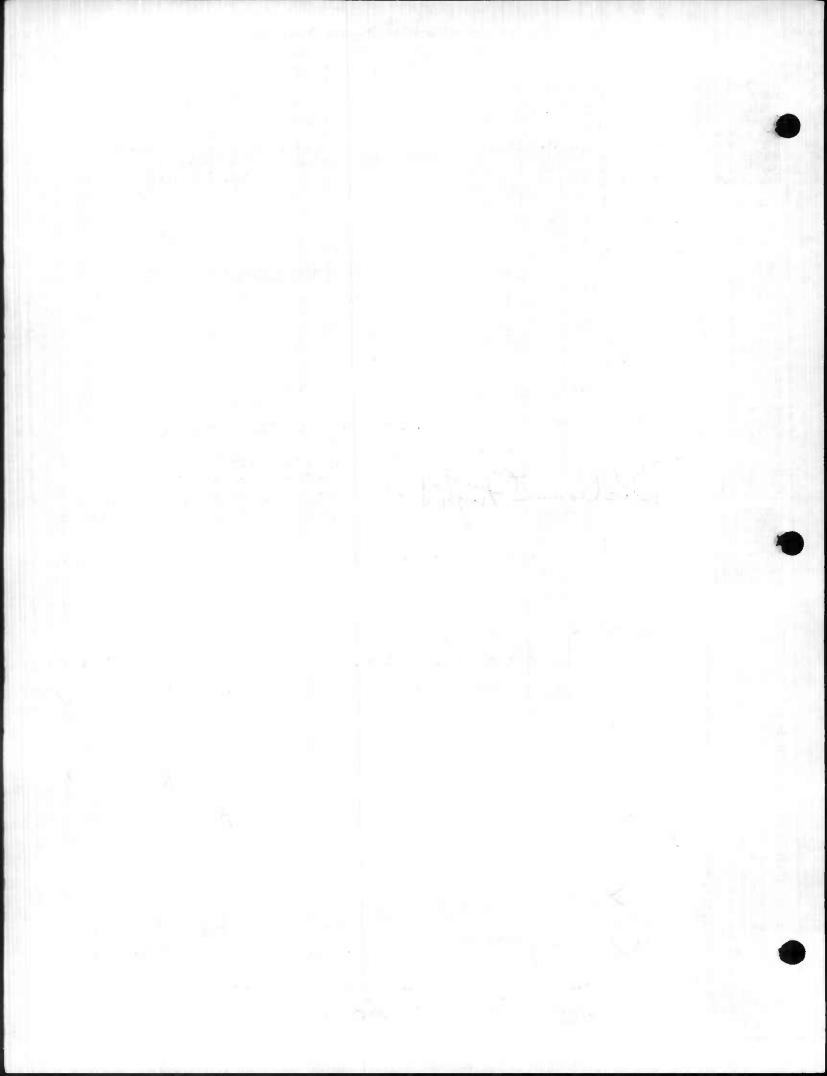


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State of Maryland / Department of Health and Mental Hygiene

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238. Part I. Entar the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrast, in the disease of conditions are considered. The disease of condition resulting in death) 258. Part I. Entar the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrast, in the disease of condition resulting in death) 258. Part I. Entar the disease, or complications that caused the deeth of the cause of the disease or condition resulting in death) 259. Part II. Entar the disease, or complications that caused the deeth of the cause of the disease or conditions conditions conditions are consequence of): 259. Due to (or as a consequence of): 259. Due to (or as a consequence of): 250	or or		1 N Burial 2 □ Cremation 3 □ i	Ramovel from Stata cer	matary, cramatory or othar ple				, , , , , , , , , , , , , , , , , , , ,
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Medical Xeminer Medical Xeminer Medical Cause (Final desasts or condition resulting in death) Medical Xeminer Septemb			23a. Part1. Entar tha disease, or comp	lications that caused the deeth.					
Due to (or as a consequence of): Correct	and I-transit	xaminer	Sequentially list conditions, if any, leading to immediate	b. ————				=	
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CORONARY ARTERY DISEASE 10 YEARS 10 YE	hysi the t	di	that initiated events	Due to (or a	as a consequence of):				
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27. Mannar of Death 1 Inpatiant 2 ER/Outpatient 3 DOA Street Accident 28d. Describe how injury occurred 27. Mannar of Death 1 Naturei 2 Accident 3 Suicida 3 Suicida 4 Homicide 28d. Describe how injury occurred 28d. Describe how injury occurre	ertifi	Be	axaminar? . f			26. Place of Dea	th (Check only ona)	
1 Nature 2 Accidant 3 Suickla 4 Homicide 1 Nature 2 Nature	dire	2	1 □ Yas 2 No	Hospital: 1 ☐ Inpatiant 2 ☐ E	R/Outpatient 3□ DOA Ot	har: 4 Nursing H	ome 5 Rasider	nca 6 Othar (Spe	cify)
28a. Place of Injury - At home, farm, streat, factory, office 28f. Location (Streat and Number or Rural Route Number of City or Town, Stata) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and Titla of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year)		Ë		28a. Data of Injury (Month, Dev Year)	28b. Tima of 28c. Inju	ry et ork?	28d. Describe how	w Injury occurred	
28a. Place of Injury - At home, farm, streat, factory, office 28f. Location (Streat and Number or Rural Route Number of City or Town, Stata) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and Titla of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year)	r: Al	atic							
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and tkia of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year)	octo by th	E	determined	28a. Place of Injury - At nom	ne, farm, straat, factory, offica		28f. Location (Stre	eat and Number or Re	ural Route Number,
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and tkia of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year)	S efte	le l		ounding, atc. (Specify)			ony or rown,	Jiaia)	
	24 hours re Funeral pietely filled		(Check only 2 Madical Exami	iner: On the basis of axaminatio	edge, death occurred at tha ti on and/or invastigation, in my	ma, date end placa, opinion, death occur	and dua to the car rrad at the time, de	usa(s) and mannar as te end place, and dua	s stated. a to tha cause(s)
	To the		29b. Signature and this of certifiar	3- 0	29c. Licen	sa number	29	d. Data signed (Mont	h, Day, Year)
D 00071 111111 1 111111 1 1 1 1 1 1 1 1 1		1	1 1	Janon	D 0	2271		T11T ** * * *	1000
D 23371 JULY 16, 1999	/			V	D 2	33/1		JULY 16,	1999
30. Name end addrass of person who complated causa of daath (Itam 23e) (Typa, Print)	6		20 Name and address of several	V	to a francis patient				
Qamar U. Zaman, M. D., 625 Kent Ave., Cumberland, MD 21502 State 31. Data filed (Month, Day, Yaar) 32. Aegistrar's Signature	6						4.500		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month DORIS VIRGINIA MARTIN Juli /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner LIONS MANOR NURSING HOME CUMBERLAND ALLEGANY If Undar 1 Year 5. Social Security Number If Undar 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 💢 F Director Yrs. 212-32-7967 JUNE 16 1922 MARYLAND Usual Rasidanca of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ALLEGANY MARYLAND CUMBERLAND 1 Yas 2 No 10e. Straat and Number 10f. Zip Code 10g. Citizen of What Country? 235 PACA STREET 21502 U.S.A. Funeral 11. Marital Status 12. Wes Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Rece - American Indien, Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Detas: 1□ Yes 2√2 No þ Specify: WHITE 3 Widowad 4 □ Divorced Completed Dacedant's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacadant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SEAMSTRESS-SELF EMPLOYED SEAMSTRESS 12 17. Fether's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Surname) Be JAMES E. SEE HELEN GRIFFEY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) JAMES E. MARTIN SON 12 SOUTH STATE STREET LANCASTER, PA. 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State CUMBERLAND CREMATORY JULY 18 1999 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND MARYLAND Signature of Funaral Service 22. Name end Addrass of Facility MERRITT-ADAMS FUNERAL HOME P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onsat and Deeth **Physician** /Medical Immediata Cause (Final diseasa or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to Immediata causa. Entar Undarlying Causa (Disease or Injury that Initiated events rasulting in daath) Last Dua to (or as/a consequence of) Box 68760, Physician/Medical the Due to (or as a consequance of): use as lor use as Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. certificate has been signed by the inector, page 2 should be detached 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ٥ Completed 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? 1 🗆 Yas 1 ☐ Yas 2 ☐ No or Attending Physicien: director, 25. Was case rafarrad to madical axaminer? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 ☐ Rasidanca 6 ☐ Other (Specify) 2 2 No 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Data of injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred After 5 Panding invastigation 1 Natural death. 1 Yes within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 8 Could not be datamined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 4 Homicida Hospital Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, daath occurred et tha tima, data and placa, and due to the causa(s) end mennar as stated.
2 Medicat Examiner: On the basis of axamination end/or invastigetion, in my opinion, deeth occurred at the tima, data and piece, and due to the causa(s) and manner statad. (Check only To the 29b. Signature end title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Yaar) Klyn 3 completed causa of death (Itam 23e) (Type, Print) 30. Nama and address of person who 6 Cumberland MD, 2302 N.A. Ranjithan. M.D. Oldtown 31. Date filed (Month, Day, Year) 32. Registrar's Signetura State

DHMH 16 Rev 6/95

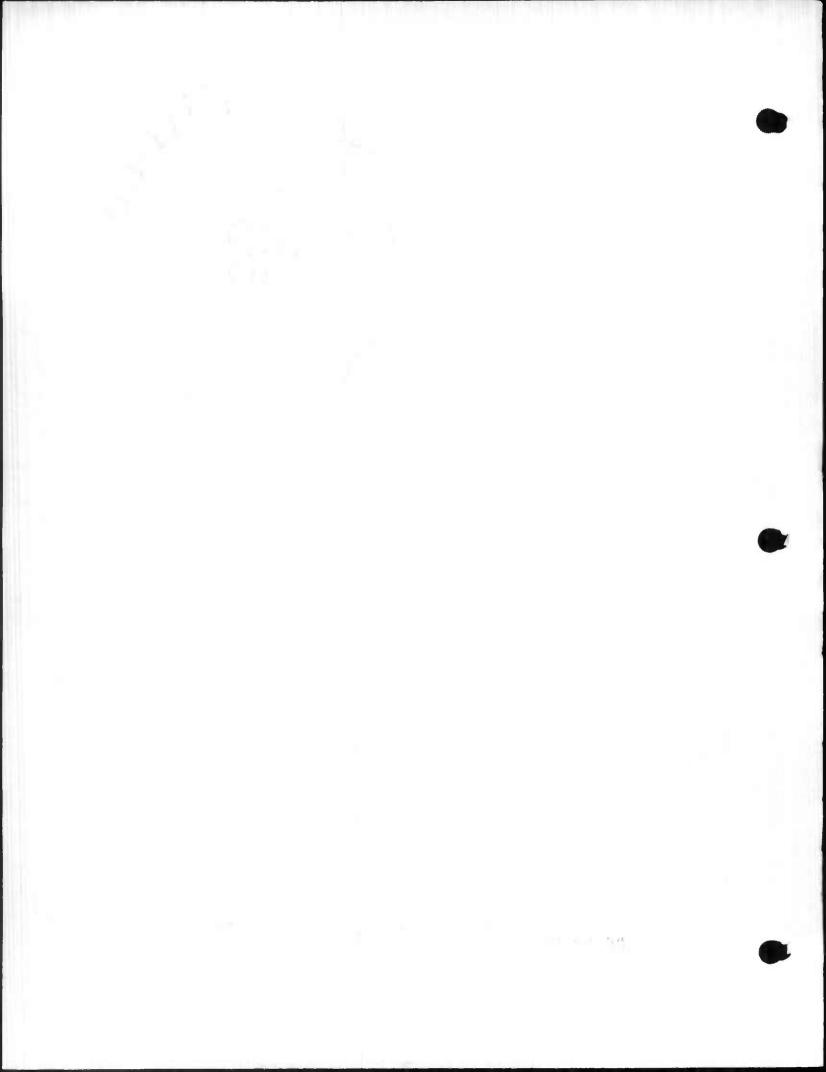
Registrar

N. Destar

DIVISION OF VITAL RECORDS, P.O. BOX 68760

I THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. I HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shoul filled within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or remonal. IPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH 3. TIME OF DEATH				
	Hiram Roosevelt	Hiram Roosevelt Metcalfe				монтн Ти17 у 1.5	1 Q Q Q	Z-15 A M			
				F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		7 • 15 a " BIRTHPLACE (State or Foreign Country)			
		M 2 □ F	83 YRS.	ONTHS DAYS	HOURS MIN.	March 3.	1916 V	West Virginia			
~	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN DR LOCATION OF DEATN 9c.							COUNTY OF DEATH			
DIRECTOR	Moran Manor Nursing Home Westernport Allegany							egany			
EC	10e. STATE 10b. COUNTY	10c. CITY, 1	TOWN DR LOCAT	TION			10d. INSIDE CITY				
	WV Mineral			Keyser							
AL	10e. STREET AND NUMBER		101. ZIP CDDE			10g. CITIZEN DF WHA					
FUNERAL	1425 Beacon Street				26726		J.S.A.				
E		2. WAS DECEDENT EVER IN FDRCES? 1 YES	MS DECEDENT EVER IN U.S. ARMED DRCES? 1 YES 2 7 NO II		ENDENT OF HISPA	NIC ORIGIN? (Specify Y	es or No 14	. RACE — American Indian, Black, White, etc.			
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR DR DA		2 ND Speci			Specify: White				
	15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OF				NA .	Last while on a					
COMPLETED	(Specify only highest grade con	(Give kind of work life. Do NOT use n	k done during mo stired.)	st of working	166. KIND OF B	OF BUSINESS/INDUSTRY					
PL	Conege (1-4 of 5+)			risor		Pulp	er Company				
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Meide		1 1			
BE C	Otis M. Metcalfe	Otis M. Metcalfe				E. Waxle	r				
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street e	(Street end Number or Rural Route Number, City or Town, State, Zip Code)						
F	Theodore L. Metcalf	e (Son)	1425 Be	eacon S	treet, K	eyser, WV	2672	26			
	20a. METNDD OF DISPOSITION 1 Burial 2 Cremation 3 Removal		PLACE AND DATE DE C		me of	DATE 20c. L	OCATION — CIT	y or Town, State			
		4 Donation 5 Other (Specify) Pot omac Memorial Cardons 7/18/99 Keyser, WV									
	21. SIGNALURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
	Hard Na	Harkwood Funeral Home 111 S. Mineral Street, Keyser, WV 26726									
	23. PART i. Enter the diseases, or com	iplications that caused	the death. Do not	enter the mo	de of dying, suc	h aa cardiac or rea	piratory arrea	t, Approximate			
	shock, or heart fallure. List only one cause on each line. Interval Between Onest and Death										
	IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Onset										
No.	Sequentially list conditions, b.	DISE TO SON AS A	20110501151101 27								
F	If any, leading to immediate cause. Enter UNDERLYING										
띮	CAUSE (Disease or injury that initiated events DUE TO (DR AS A CONSEQUENCE OF):										
CERTIFICATION	resulting in death) LAST	that unitated events									
	PART II Oshor el-sillares and distance										
N N								24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO			
MEDIC	1 U YES 2 XX NO						OF DEATH?				
Z	DID TODACCO LICE CONTRIBUTE TO CAUSE OF DATE:										
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN 1										
S	EXAMINER? HOSPITAL: OTHER:										
¥	1 YES 2 ND 1	Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Nome 5 1 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT				lesidence 6 Other (Specify) 28d. DESCRIBE NOW INJURY OCCURED					
	1 Netural 5 Pending	(Month, Day, Year)	(Month, Day, Year) INJURY M 1 Y 28a. PLACE OF INJURY — At home, farm, street, factory, office			ORK? YES 2 NO		et and Number or Rural Route Number,			
) BY	2 Accident Investigation	26a. PLACE OF INJURY	At home, farm, street	4 Homicide determined building, etc. (Specify)							
	2 Accident Investigation 3 Suicide 6 Could not be	26s, PLACE OF INJURY building, etc. (Special	— At home, farm, stree (y)	or, reasony, office		City or Town, Stet	9)				
	2 Accident Investigation 3 Suicide 6 Could not be determined	building, etc. (Special	9)			City or Town, Stet	9)				
	2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only)	N: To the best of my knowle	odge, death occurred a	t the time, date	and placs, and due	City or Town, Stell	enner se stated.	ause(e) and manner as stated.			
COMPLETED	2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only)	N: To the best of my knowle	odge, death occurred a	t the time, date	and placs, and due	City or Yown, Stet to the cause(e) and m time, date and place, a	enner se stated.	suse(e) and manner as stated.			
BE COMPLETED	2 Accident 3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 0	N: To the best of my knowle	odge, death occurred a	t the time, date	and placs, and due	City or Yown, Stet to the cause(e) and m time, date and place, a	enner se stated. and due to the c	IGNED (Month, Day, Year)			
COMPLETED	2 Accident 3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 0	N: To the best of my knowled on the basis of examination	y/ odge, death occurred a end/or investigation, i	nt the time, date n my opinion, d	and placs, and due eath occured at the 29c. LICENSE NUI	City or Yown, Stet to the cause(e) and m time, date and place, a	enner se stated. and due to the c				
BIE COMPLETED	2 Accident 3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 0 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO	N: To the best of my knowled on the basis of examination	odge, death occurred a end/or investigation, in the control of the	nt the time, date in my opinion, d	and placs, and due eath occured at the 29c. LICENSE NUI D21244	City or Town, Stet to the cause(s) and m time, date and place, s	enner se stated. and due to the c 29d. DATE S Jul	IGNED (Month, Day, Year)			
BIE COMPLETED	2 Accident 3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only orne) 2 MEDICAL EXAMINER: 0 29b. SIGNATURE AND TITLE OF CERTIFIER	N: To the best of my knowled on the basis of examination OMPLETED CAUSE OF DEA I. D., Frostbu 32. REGIS HAR'S SIGNA	odge, death occurred a end/or investigation, in the (ITEM 27) (Type, Printing Plazsa	nt the time, date in my opinion, d	and placs, and due eath occured at the 29c. LICENSE NUI D21244 tburg, M	City or Town, Stet to the cause(s) and m time, date and place, s	enner se stated. and due to the c 29d. DATE S Jul	IGNED (Month, Day, Year)			



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State of Maryland / Department of Health and Mental Hygiene

				(Certificate		eath		g. No.	2	3680		
	Physician	1. Decedent's Neme (First, Middle, Last)					2. Date of Death Month Day Ye		Year	3. Time of Death			
	/Medical	Margaret Louise Martin				JULY		10 1999		7:00 AM			
	Examiner	4a Facility Name (If not Institution,					City, Town, or Lo mberland	cation of Death	4c. County				
-	Funeral	Sacred Heart Hospit 5. Social Security Number		e (In yrs. last birth	day) If Under	1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthol	ace (State or Foreign		
	Director	218-12-5035 Usuel Residence of Decedent	1□M 2X0F 77	Yı	Months .	Days	Hours Min.	11-Mar-2	Year)	Varylo			
Maryland 21215-0020	ylend	10a. State 10b. County		10c. City, Town	or Location					10	Od. Inside City Limits		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural", or frams 23a or 28a-f show any Injury or other traumatic event, the Medical Emirates must be notified at once. To Be Completed by Funeral Director	Maryland Allega	Maryland Allegany Frostburg 10,100 ≥ 1								1 Diyes 2 □ No		
		10e. Street and Number 51 Brodway 10f. Zip Code 10g. Citizen of What Country? U.S.A.											
		11. Meritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:			I.S. Wes Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:				No- 14. Race - American Indian, Black, White, etc. Specific				
	72 ho	15. Decedent's Education (Specify only highest grade completed)			ecedent's Usual Give kind of worl	l Occupati k done du	on ring most of work	ina	16b. Kind of Business/Industry				
	led within 72 hours in the than "natural", of the Western East. Completed by	Elementery/Secondary (0-12) College (1-4or 5+)			ife. DO NOT use	e retired)							
	C at the	12 0 17. Father's Neme (First, Middle, Last)			ork	1	8 Mother's Name		Boller Makers Me, Maiden Surname)				
	d be fill He out a contact He out out out out out out out out out out		add,				ilda Delan			<i>.</i> ,			
	should Men marke marke	19a. Informant's Name/Relationsh	p (Type, Print)	19b. I	Mailing Address		d Number or Run		City or Town,	State, Zip	Code)		
	od 2 27 is	Agnes Fisher	Sister	110	008 Welsh H	ill Road	s.w. Fros	tbura	Marylai	nd 2	1532-		
ore,	of Heri	20a. Method of Disposition		20b. Place of E	Disposition (Nam crematory or off	e of			20c. Location - City or Town, St		wn, State		
E	Page nent commit: if	1 Burial 2 Cremation 4 Donation 5 Other (Sp.			l's Parish Ce			2-Jul-99 Fr	ostburg, A	Marylo	ind		
Baltimore,	permit. Departri Importa any Inju	21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532											
		23a. Parl 1. Enter the disease, or o	omplications that caused	the death. Do no	t enter the mode	of dying,	such as cardiac	or respiratory arm	est,	1	Approximate Interval Between		
1	Physician /Medical Examiner sthe purial-transit sthe burial-transit edical Examiner	Onset and Death											
		Immediate Cause (Finel disease or condition	disease or condition										
		resulting in death)		Due to (or as a co	nsequence of):					t			
			b							-			
-	ificate be executed gphysician and as the burial-transit ledical Examir	Sequentially list conditions, if any, leeding to immediate	Sequentially list conditions, Due to (or as a consequence of): If any, leading to immediate										
68760,	e be sicial	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
	5 00 5												
Box	at the death cert d by the ettending ettached for use Physician/M									1			
P.0.	the de ched	Part II. Other algnificant conditions contributing to death but not resul							id tobecco use contribute to the cause of death?				
	ires that the death cert signed by the ettendin id be detached for use d by Physician/N	CHEONIC SESSEMETIVE LUNG DISEASE					1 Yes 2 No 3 OProbably 4 U						
Division of Vital Records,	been shoul	COKONANY ANTELY DURANE				24a. W			erformed? availal		ore autopsy findings silable prior to inpletion of cause		
	The law ate has page 2	CONGESTIVE		TINASE				1 D Y	s 2QNo		Yes 2 No		
	certificate irector, pag	25. Was case referred to medical	I Pentil J-	TIMARIE		-	26. Place of Deat						
	hysicien: his certifical director, To Be (examiner? 1 Yes 2 No	Hospital: 1 Danpatie	nt 2 ER/Outp	etient 3 DO	Other		me 5 Reside		er (Specify	1)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, Medical Certification: To Be (27. Menner of Death 1 Naturel 5 Pending 2 Accident investigs		The state of the s				28d. Describe how injury occurred					
		3 Suicide 6 Could no determine	ury - At home, fam (Specify)					ion (Street and Number or Flural Route Number, ir Town, State)					
		29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	withir comp	29b. Signature and title of certifier 29c. License number					number	29d. Date signed (Month, Day, Year)			Day, Year)		
	- 1	Horas	Stroth				128907				JULY 10 1999		
	CU	30. Name and address of person w					0	,		,			
	9	Hargit Sidhus			alsh Ko	ad 1	Cumber	land X	10 2	150	2		
	State Registrar	31. Date filed (Month, Day, Year)	32. Registre	ar's Signature	4	/							

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CL VODSBU Fach Centley 12-Jul-99 Bodburg Muyland

Durst reneral Home. St Frost Ave., Her may An 2133

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** Ida Mae Snyder JULY 1999 7:38 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Sacred Heart Hospital Cumberland If Under 24 Hrs. If Under 1 Ye Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□M 2 F 211-12-5370 76 03-May-23 Director Pennsylvania Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show mant be notified at 1 Yes 2 No Directo Maryland Allegany Mount Savage 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with 8 13106 Yellow Row Road, N.W. Rems 23s 21545-U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if frem 27 ie marked other than "natural", or then any injury or other traumatic event, the Head at a pance. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specifyite by 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 seamstress clothing maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank R. Brown Edna Mae Mishler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Allan E. Snyder, Jr. Frostburg Maryland 21532-211 Barnard Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Methodist Cemetery 14-Jul-99 4 □ Donation 5 □ Other (Specify) Mount Savage, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility blus Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Paol. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final my ocordial In farction disease or condition resulting in death) hour Examiner Examiner The law requires that the death certificate be executed attending physician and for usa as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. the the signed by t 1 Yes 2 No 3 Probably 4 Inknown pertension à 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peed completion of cause of death? 1 Yes 25 No 1 ☐ Yes 2 ☐ No certificata director, 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: SONO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3200A Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera After Natural Accident 5 Panding 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) Ž 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License number wa D21244 121999 JULY Name and address of person who completed cause of death (from 23a) (Type, Print)
 Jesus H. Tan, M.D., Frostburg Plaza, Frostburg, Maryland 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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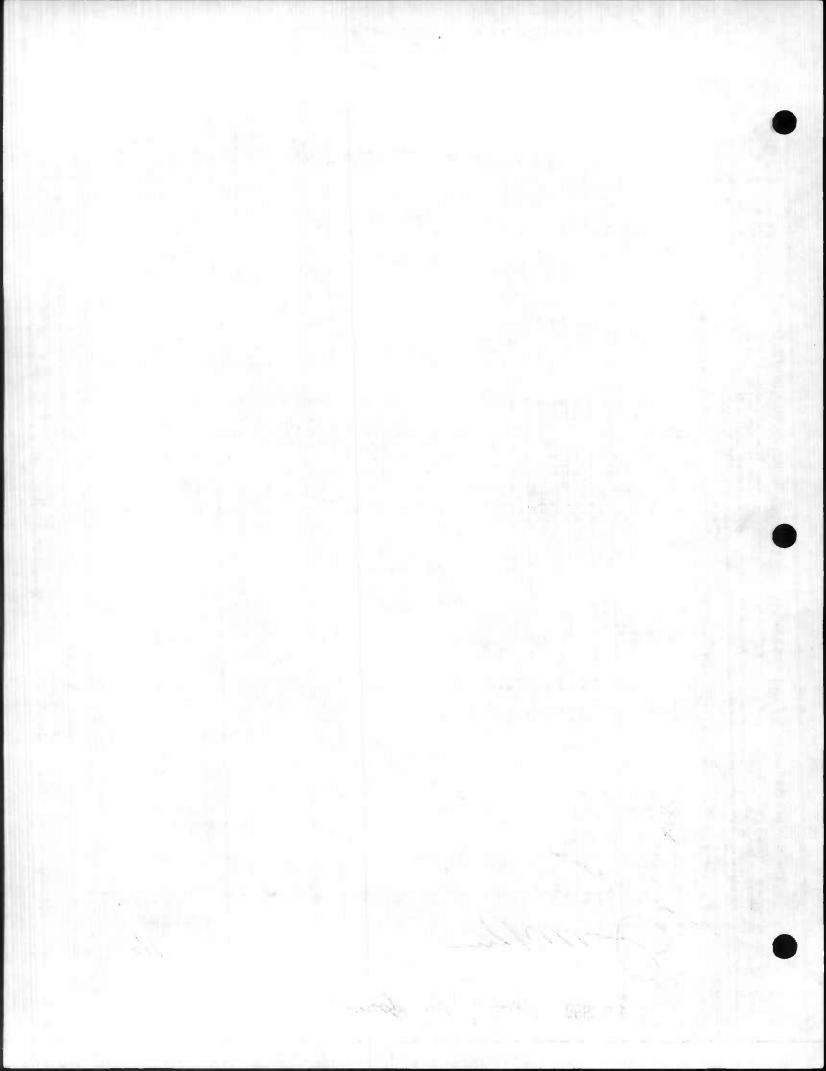
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State of Maryland / Department of Health and Mental Hygiene

			Cei	tificate of	Death		Reg. No.	23682			
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Examine	An Coults, Name /Mant tooth stee after	street and number)			4b. City, Town,	or Location of Deat					
	MEMORIAL HOSPITAL				CUMBERLA	ERLAND ALLEGANY					
Funeral Director	218-38-0750	1 M 2 NE				rs. 8. Data of Bir (Month, De Jun 26					
land land	Usual Residence of Decedent 10a. Stata 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits			
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th with th	MD Allegar 10e. Street and Number 21714 National Pil 11. Merital Status 1 Never Married 2 Married		10g. Citizen of What Country? USA								
020	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Detes:	No 1□ Yes 24 No			lispanic Origin? (Specify Yas or No- an, Mexican, Puerto Rican, etc.) Specify:		14. Race - American Indian, Bleck, White, atc. Specify: White			
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with the same of t	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)						VanMeter'	s Grocery			
D E F	17. Father's Name (First, Middla, Last)				rmer Owner/Operator VanMeter 18. Mother's Nama (First, Middle, Maiden Sumame)						
Maryland ad 2 should be file lith and Mental Hy 77 Is marked other fraumatic avant	17. Father's Name (First, Middla, Last) George Self					Lula (Nelson)					
A Marie	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Maitin	g Address (Stree	-		er, City or Town, S	tata, Zip Code)			
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Baltimore, R pemil. Peges 1 and Department of Haalth Important: If then 27 any Injury or other to	20a. Method of Disposition 14 Burial 2 Cremetion 3 1	Removal from State		natory or other pl		Date 07/05		ity or Town, Stata			
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20240	Cumberland, MD 21502										
Physician	shock, or heart faitura. List only	Approximate interval Batween Onset and Death									
/Medical Examiner	Immediete Cause (Finat disease or condition as BILATERAL ACUTE PNEUMOTHORACES resulting in death)							20 MINUTES			
		30 MINUTES									
bensit	Sequentially list conditions	ACUTE PNEUMOMEDIASTINUM Due to (or as a consequence of):									
ceta be executed physician and the burletransit	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ACUTE RESPIRATORY FAILURE + MECHANICAL VENTILATION					TTLATION	1 HOUR			
ficeta be ex physician as the buriel	that initiated events resulting in death) Last	Due to (or as a consequence of):				WICKE VER	ITENTION	1 HOOK			
BOX OR BATH Certification of the certification of t	L	d ACUTE ANAPHYLAXIS					1 HOUR				
daeth daeth	Pert II. Other significant conditions con	ntributing to death but not	rasulting in the ur	ndertvino causa o	iven in Part I.	23b. Did	tobacco usa contr	ributs to the cause of death?			
	Pert II. Other significant conditions con CHRONIC OBSTRUCTIV		1 Yes 2 No 3 Probably 4 Unkn								
	CONGESTIVE HEART	LAR DIS	EASE	24e. Wes an autopsy parlormed? 24b. Were autopsy available prior to completion of confideath.							
The law state hest page 2 e						10	Yes 212No	1 Yes 2 No			
artifica clor, p	25. Was case referred to medical				26. Place of D	eath (Check only					
Physician: Physician: ral director,	examiner?	lospital:	ER/Outpatien	1 3 DOA 0	ther		idence 6 Othar	(Specify)			
Attending Physicien: The lav or death. ector: After this cardificate has by the funeral director, page 2		28a. Data of Injury (Month, Day Year	28b. Time of 28c. Injury at 28d. Describe how injury occurred					d:			
bell or Attending P rs etter dash. al Director: After i ed in by the funer.	3 Suicide 6 Could not be detarmined	28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)			28f. Location (City or To	M. Location (Street and Number or Rural Route Number, City or Town, Stata)					
	29a Centher (Check only one) 1. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the eause(s) and manner as the control of										
ro th To th	29b. Signature and little of certifier	26		29c. Licer	ise number		29d. Date signed (Month, Day, Year)				
2	1//00//	possible and			D 18769			July /6 , 1999			
3	30. Name and address of person who co	ompleted causa of death (I	item 23a) (Type, i					, .,,,			
nes	James M. Raver, M.	D.; Western	Marylan	d Health	System	, Seton D	rive, Cum	berland, MD 21502			
State Registra	31. Date filed (Month, Day, Year)	32. Registrar's S	natura	conto							



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State of Maryland / Department of Health and Mental Hygiene \(\) 23683 Certificate of Death 3. Time of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) Month **Physician** 1999 LORETTA CECELIA WHETSTONE JULY 11:40 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner ALLEGANY 72 HILL STREET FROSTBURG If Undar 1 Yaar If Undar 24 Hrs. 8, Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2XF Yrs MARYLAND Director 86 SEPT 13 1912 213 22 4547 Usual Rasidance of Decedant with the Maryland 10c. City, Town or Location 10d. Insida City Limits r than "natural", or itema 23a or 28a-f above the Medical Examinar must be notified at 1X Yas 2 No Directo MARYLAND ALLEGANY FROSTBURG 10f. Zip Coda 10g. Citizen of What Country? 10e Street and Number 21532 U.S. 72 HILL STREET Funeral death 12. Was Decedanf Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural," or frem any injury or other traumatic event, the Medical Exercises and December 1 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 □ Navar Marriad 2 □ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: P 3√2 Widowed 4 □ Divorced WHITE Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) CANDY MAKER CANDY 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) CATHERINE CANNING JOHN CALLERY 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 39 GREEN ST., FROSTBURG, MD 21532 ELSIE ADAMS/ DAUGHTER 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata
4 Donation 5 Other (Specify) MICHAEL'S CEMETERY 7/10/99 FROSTBURG, MD 22. Nama and Addrass of Facility
SOWERS FUNERAL HOME, P.A. 21. Signature of Funaral Sarvice Licansee 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part 1. Entar the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death Physician /Medical Immediata Cause (Final disaasa or condition rasulting In daath) a. CARDIAC DYSRHYTHMIA

Dua to (or as a consequence of): Hours Examiner Examiner attending physician and for use es the bunial-transit deeth certificate be executed Saquantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequanca of): es the P.0. Did tobacciouse contributa to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown DegeneraTiVE ARTHRITIS Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an sutopsy performed? Completed completion of cause of death? page 2 s 2 PN 1 Yes 1 □ Yas 2 □ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? released Be 26. Place of Death (Check only one) 12 Yes 20 No 20 No Hospital: Other: 4 Nursing Homa 5 Fasidance 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 5 Panding 1 Yes 2 No death. Invastigation 2 Accident Director: 6 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida Piaca of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) filled in by 4 Homicida 24 hours e 29a. Certifier 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 256 38 Wn 30. Nama and addrass of person who suppleted cause of death (Item 23a) (Type, Print)

State Registrar

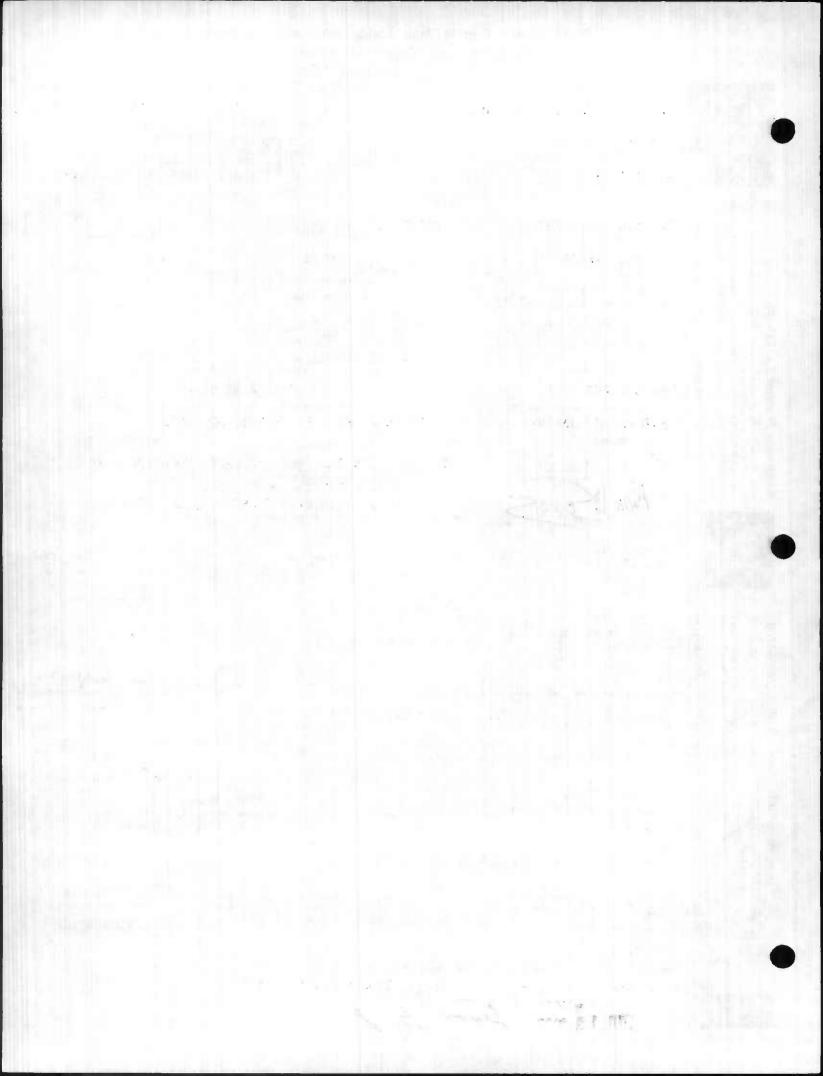
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T. Chang, M.D., 31. Data filed (Month, Day, Yaar) ---

32. Registrar's Signatura

Frostburg Plaza, Frostburg, MD 21532

DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene 🎙 🖓 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month LEO MELVIN WALIZER 1999 JULY 12 4:15 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner ST VINCENT DE PAUL NURSING HOME FROSTBURG AT.I.E.GANY If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Birthplace (State or Foreign Country) 1⊠M 2□ F 220-07-6897 87 Yrs. Director MARYLAND JUNE 3 1912 Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2X No ALLEGANY CORRIGANVILLE MARYLAND 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 21524 11615 MT SAVAGE ROAD N.W. U.S.A. death Funerai 12. Was Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Deles: WW11 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Bieck, White, etc. permit. Pagas 1 and 2 should be filed within 72 hours after to Department of Haelth and Mental Hygiene, important: If item 27 is merked other than "natural", or hamany injury or other traument. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Po Specify: þ Specify: WHITE 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) KELLY SPRINGFIELD TIRE CO. TIRE BUILDER 17 Fether's Neme /First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) SON ROYCE W. WALIZER P.O.BOX# 1011 FORT ASHBY, W.VA. 20b. Plece of Disposition (Name of cometery, cremetory or other p 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SUNSET CEMETERY JULY 14 1999 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. a. 404 DECATUR STREET CUMBERLAND MARYLAND 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner bunial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician and Box 68760. Physician/Medicai the Due to (or as a consequence of) P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 9☐ Probably 4☐ Unknown signed b Records, by 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 24e. Was en eutopsy performed? Be Completed peed cartificate 1 ☐ Yes 2 X No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

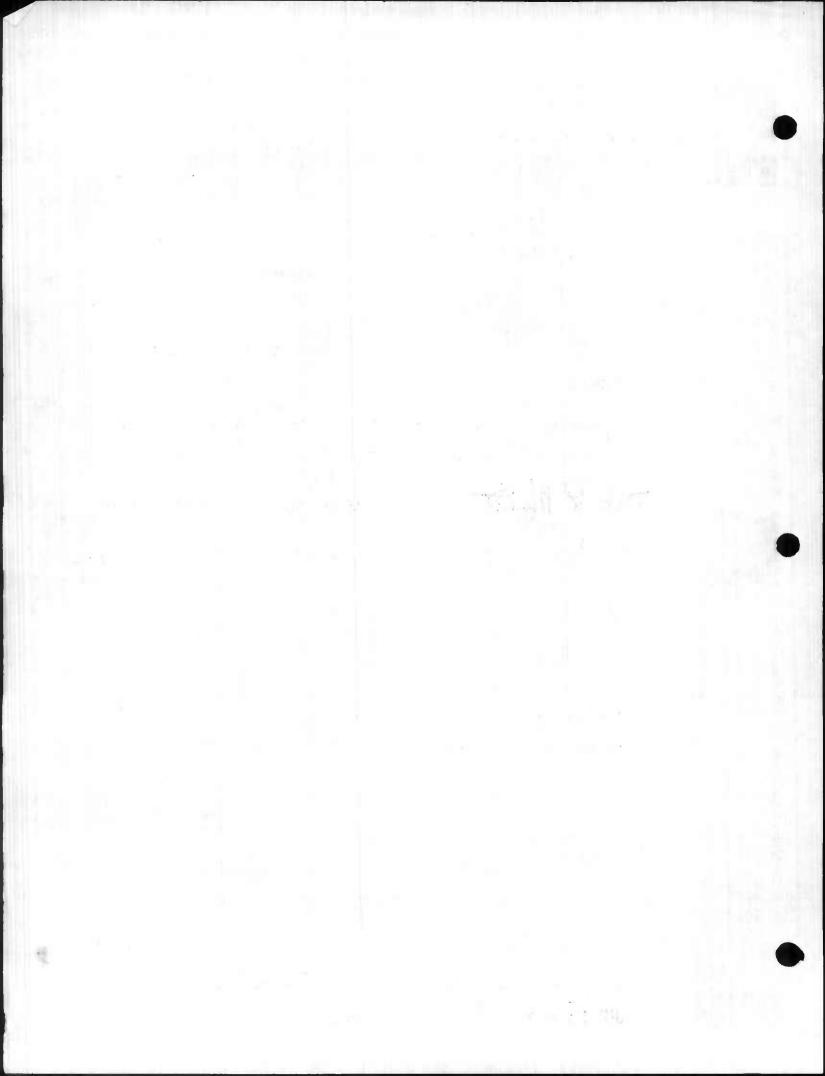
To the Funeral Director: After this cartifica completely filled in by the funeral director, I 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 100 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Madical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner steted. 29e. Certifier Medicai (Check only 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D 21244 JULY 13, 1999 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) DR JESUS H. TAN FROSTBURG PLAZA FROSTBURG, MARYLAND 31. Dete filed (Month, Dev. Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

JUL 1 3 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 23685 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 1999 2332PM onna Lee Hnderson Ju 4b. City, 10wn, or Leading 10 Capital Heights 10 Hours Min. 8. Dete of Birth (Month, Day, Year) 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth Avenue Prince George's Arcadia 1901 7. Age (In yrs. last birthdey) 5. Sociel Security Number 6. Sex 1 ☐ M 2 1 F 67 Yrs. Oct.17,1931 243-40-0154 Usuel Residence of Decedent 10a Stete 10h County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 □ No Prince Georges MD. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue 20743 1901 Arcadia United States 12. Wes Decedent Ever In U,S. Armed Forces?
1 Yes 2 No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien 11. Maritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) waitress Private 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) unknown unknown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Son Arcadia 1901 Ave. Hgts. Anderson Md 20743 ImoTh 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c-Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 7-16-99 Suitland, MD. 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signeture of Funerel Servica Licenses 22. Name end Address of Fecility Hodges & Edwards F.H. Edwards 3910 Silver Hill RD. Suitland, MD. 20746 23a. P.n1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth fmmediate Ceuse (Finel ferotic Cardiovascular Direcese diseese or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequenca of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings evelleble prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Placa of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Sulcide 6 Could not be determined

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Physician

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7 is marked other traumatic event, t

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permit. Page Department of Important: If any injury or

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

altimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed director, Be P Certification:

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, d for use as t ed by the a signed t s certificate has lirector, page 2 s Hospital or Attanding Physician: this After death. after death within 24 hours at To the Funeral D completely filled

> State Registrar

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31. Dete filed (Month, Day Year)
JUL 2 8 1999

29b. Signeture end title of certifie

30. Name and address of person

4 Homicide

(Check only one)

29e. Certifier

who completed cause of deeth (ftem 23a) (Type, Print) 32 Registrer's Signature

Do

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Chevy

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated.

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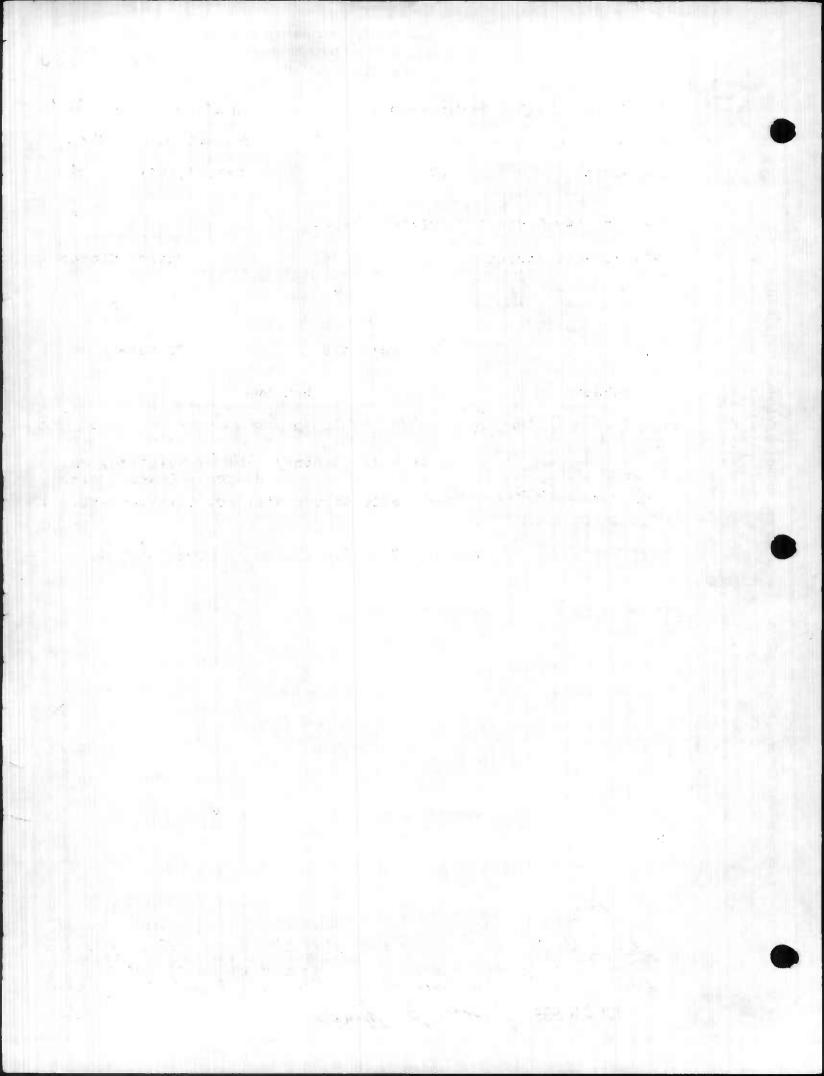
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

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To the



Division of Vital Records, P.O. Box 68760

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Certification:

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State Registrar

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eted cause ot death (Item 23e) (Type, Print) 2000 W. BALTIMORE

within 2 To the

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month 9:00 AM 99 13 CHRISTINE 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death P.G. Clinton 8500 Mike Shapiro Drive If Undar 1 Yaar | If Under 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Day, Year) Months Days Hours Min 1□M 252 F Yrs. S.C. 80 6/11/1919 063-22-0014 Usual Residence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. inside City Limits Y Yes 2 No P.G, MD Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 U.S.A. 8500 Mike Shapiro Dr. 14. Race - American Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 Yes 2 No If Yas, Giva Yaar or Datas: 1 Never Married 2 Married 1 ☐ Yes & ☐ No Specify: Specify: Black ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) private 12 Dietary Aid 16. Mothar's Name (First, Middla, Maldan Sumama) 17. Fathar's Name (First, Middle, Last) Ella Parks Willie Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Camellia McKie 10301 King Richard PL. Upper Marl.MD.20772 20b. Place of Disposition (Nama of cematary, crematory or othar place) 20a. Method of Disposition 20c. Location - City or Town, Stata X□ Burial 2 □ Cremation 3 □ Ramoval from Stata 7/19/99 Brentwood, MD. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 22. Nama and Address of Facility Hodges and Edwards 21. Sign re of Funeral Service Licensee 3910 Silver Hill RD.Suitland, Md. 20746 Yar1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, spock, or heart failure. List only one cause on each line. Approximete fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 years menta Due to (or es a consequence of) Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 Probably 4 Unknown ypertension 24b. Were autopsy findings available prior to Vascular desease 24a. Wes an autopsy performed? completion of causa of death? 1 ☐ Yes 🏖 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 26d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 26f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28e. Place of fnjury - At homa, farm, straet, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760

Physician

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experient must be not a set as

Physician /Medical

Examiner

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29a. Certifier

Baltimore, Maryland 21215-0020

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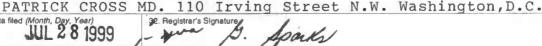
> State Registrar

31. Data filed (Month, Day, Year)
JUL 28 1999

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signatura and little of certifian



150 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

19923

29d. Data signed (Month, Day, Year)

July 28, 1999

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Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notfiled at once.

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P.O. Box 68760

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State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death 17 July 1999 Gladyson I. Ayres 12:20 PM 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Perry Point Cecil VA Maryland Health Care System If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) Deys 1X) M 2□ F Yrs. 82 212-16-4292 Aug. 31, 1916 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Pylesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 Old St.Mary's Road 21132 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 11. Meritei Stetus 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white b 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Carpenter Lumber Company 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Archer Ayres Annie Bertha Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Old St. Mary's Road, Pylesville, MD 21131 Sarah Ayres/spouse 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Joseph B Vao Sant State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201

23e. Pert1. Ent the dise ise, complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) . Cardiopulmonary Arrest Unknown Due to (or es e consequenca ot): Cardiac Arrhythmia (Chronic Atrial Fibrillation) Unknown Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence ot): Unknown Coronary Artery Disease Due to (or es e consequence of): Unknown d Dementia 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical exeminer? 26. Placa of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner ot Deeth 1 XNeturel 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 29e. Certifier 1 🔀 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end mainer stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number amosmo Nanu D38950 July 18, 1999 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

31. Dete filed (Month, Day, Year) JUL 2 8 1999

MANUEL RAMOS, M.D., VA Maryland Health Care System, Perry Point, MD 32. Registrer's Signeture ports

DHMH 16 Rav 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dafe of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month JULY 25 Dey 1999 Edith Beatrice Brice 2300 4b. City. Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not Institution, give street end number) Saint Agnes Hospital Baltimore n/a If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Securify Number 7. Age (In yrs. last birthday) 213-36-0584 1 M 3EXF 62 Yrs. Nov. 12, 1936 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits n/a Yes 2 No Baltimore 10e. Sfreef end Number 10f. Zip Code 10g. Citizen of What Country? 21216 2504 Garrison BLVD USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedenf Ever in U,S. Armed Forces? 11. Merifal Status ☐ Yes 25 No Yes, Give 1 Never Merried 2 Married 1 ☐ Yes No Specify: Specify: Black 3 Widowed 4 □ Divorced Year or Detes: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Health Care Provider Bon Secours 11th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Ernest R. Morsley Dorothy Jenkins 19e. Informent's Neme/Reletionship (Type, Print) sister 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Camille Cook 2504 Garrison BLVD. Baltimore, Md. 21216 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stefe 20e, Method of Disposition 15 Buriel 2 Cremetlon 3 Remova from Stete Aug. 2 Owings Mills, Md. Garrison Forrest Veterans 5 Other (Specify) 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signeture of Funeral Pervice Linnsee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Pert1. Enter the disease, or complications that calls to the deeth. Do not enter the mode of dyling, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on a spin ine. Approximete interval Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) Myocardial Hours. eans Tery Coronary Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): ertons u Due to (or as a consequence of): oun ache Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Cancer medor 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes an eutopsy performed? 1 ☐ Yes 2 4 No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Menne of Death 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 1 Naturel 5 Pending Investigation

Physician /Medical Examiner

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> State Registrar

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JUL 2 8 1999

29b. Signature and fitte of certifier

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

Mohammad Saleon, mn

29c. License number 1940610

1D Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, deta and place, and due to the cause(s) and menner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year) July 26, 1999,

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

ST. AGNES HOSP. ER.

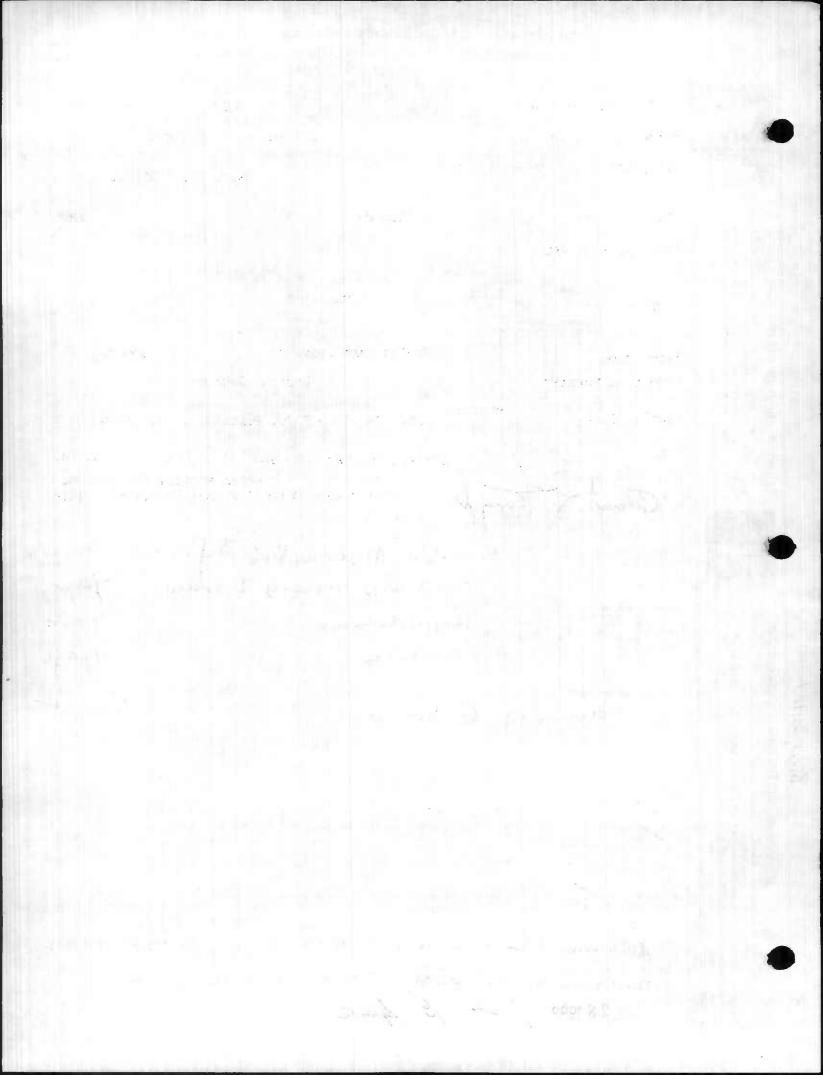
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32. Registrer's Signeture

28e. Plece of Injury - At home, ferm, sfreef, factory, office building, etc. (Specify)

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If Under 24 Hrs. 8, D 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yaar 1□ M 2 KF 218-28-25 Months Days Hours Min 98 Yrs. Usuel Rasidence of Decedant 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore NA 1 TYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21216 Huenue 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritel Stetus 14. Race - Amarican Indien. Black, White, etc. 1 Never Merried 2 Merried ☐ Yas 2 No Yes, Give 1□ Yes 2Ū No Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest greda completed) 16a. Decedent's Usuel Occupation
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16a. 16b. Kind of Business/Industry College (1-4or 5+) ietician 12 Hosp, tak Jyrs 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Harder Eugene Augus tus
190. Informent's Neme/Reletionship (Type, Print) Josephina 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Balto, Md hte 3116 Oak 20b. Plece of Disposition (Name of Oak Reld Elizabeth Watt -Daughter nue 20e, Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☑ Byriel 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Ponation 5 ☐ Other (Specify) cematery, cremetory or other plece) Memorial Kank ure of Funerel Service Licensae 22. Name end Addrass of Facility Enter the disease, or complications that callsed the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feiture. List only one ceuse on each line. Seeme Balto, red 21215 Approximate Interval Between Onsat end Deeth Immediete Cause (Final disaesa or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that immated events resulting in death) Last Due to (or es e consequence of) Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death?

P.O. Box 68760, 3 Division of Vital Records, Aftar this cartificata has death.

Physician/Medical Examiner Tha law requires that the death certificate be axec þ Be Completed or Attending Physician: Medical Certification: To To the Hospital or Attendi within 24 hours aftar death. To the Funeral Director: A

Physician

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Item 27 is marked other than "natural", or items 23s or 28s-f shor other traumatic event, the Medical Examiner must be notified at

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Department of F Important: If Its any injury or of once.

Physician

/Medical Examiner

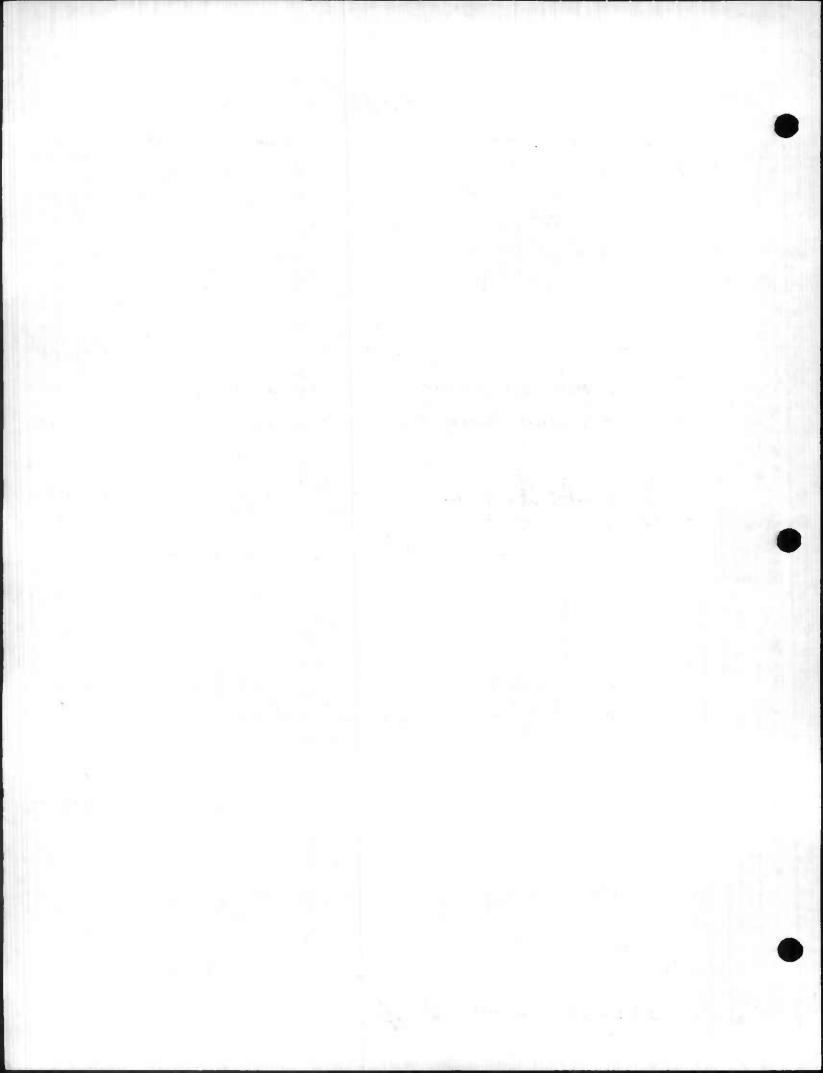
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	,		1	24e. Wes an autopsy performed?	24b. Were autopsy findings available prior to completton of cause of deeth?				
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1 Yas 2 No	Hospitel: 1 Inpatient 2 ER/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Menner of Deeth 1 Maturel 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how Injury occurr	ed				
3 Sulcide 6 Could not be determined		ome, ferm, streat, fed	281. Location (Straet and Number City or Town, Stete)	8f. Location (Straet and Number or Rural Route Number, City or Town, Stete)					
29e. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of my knominar: On the basis of examined and menner stated.	owledge, deeth occurretion end/or investigat	red et the time, dete end plection, in my opinion, deeth occ	ce, end due to the ceuse(s) and me curred et the tima, date and plece, e	nner es steted. and due to the cause(s)				
29b. Signature and title of certifiar	1) ,		29c. Licansa number	29d. Data signed	(Month, Dey, Year)				

State Registrar 31. Dete filed (Month, Dey, Yeer) 2.8 1999

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARSHAN. S. SALUJAMD 1600 MOUNT Royal Are, Ballo 21217 ??. Registrer's Signature

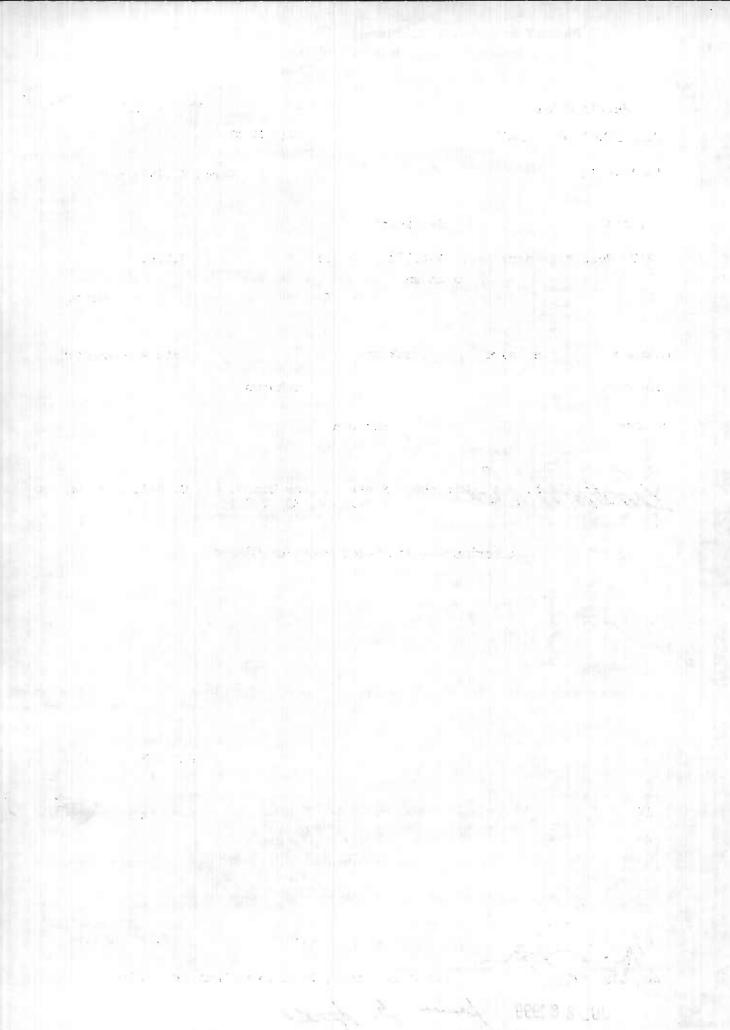
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Physician '/Medical Examiner		Melvin Cohe	n					Month JUNE	23, 19	Yeer 99	1641 PM
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	Funeral Director	216-28-6930	Sex 101 M 2 F	8 Yrs.	Months [Year If Under Deys Hours	Min. M	Date of Birth (Month, Day, arch 2	Year) 7,1931	9. Birthpl Count unkno	ece (Stete or Foreign (ry) (WI)
	and and	Usuel Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or I	ocation					10	Od. Inside City Limits
	vary or	Marvil and Relations									1 X Yes 2 □ No
	ours after death with the Marylar et's, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	Maryland Baltimore 10e. Street and Number 10f. Zip Code						1	Og. Citizen of V	Whet Count	lry?
	3a o	2500 West Belv	edere Ave An	+ 720	212	15		TT	S.A.		
	r items 23a	11. Maritel Status						14. Rec	e - America		
o	or its		12. Wes Decedent Ever in Armed Forces?UNKT	IOWII							
21215-0020	within 72 hours after death with the Maryland one. Then "naturel", or items 23s or 28s-f show the Medical Evantiner must be notified at the property of the Puneral Director property of the property of the Puneral Director		Yeer or Detes:		1 ☐ Yes 2 X No		•		Specify: white		te
0	ed within /2 hours ygiene. Ner than "naturel", It, I've Medical Eve Completed by	15. Decedent's E (Specify only highest g	Education rede completed)	16e. Decedent's Usuel Occupation (Give kind of work done during most of work					16b. Kind of B	usiness/Ind	ustry
7	than than	Elementery/Secondary (0-12)		life. DO NOT use retired)				2			
A	7 7 1	unknown 17. Fether's Neme (First, Middle, Las					er's Neme /	State Government ome (First, Middle, Maiden Surname)			
	ked off ic ever ic ever		51/								
	o z should be filed the end Mental Hyg 7 is marked othe traumatic event, To Be C	19e. informent's Neme/Reletionship	(Type Print)	Time Points 10h Molling Address (C			unknown eet and Number or Rural Route Number, City or Town, St			State Zin	Code)
_ (300 Sec. 11/4 - C. 11/4 -	unknown 20b. Plece of Disposition (Name of cemetery, cremetory or other			ard Ivamo	or or rioral r	rai riosio riainoor, ony or romi, onoto,		Olele, Zip	0000)
ຍົ .	other tr	unknown 20e. Method of Disposition				of	Dete		20c. Location - City or Town, Stete		wn, Stete
	int of the First of Or or or or or or or or or or or or or or	1 Burial 2 Cremetion 3				r plece)					
baltimore,	permit. Pages Pepartment of Important: If the any Injury or ot once.	4 Donetion 5 Other (Spec		22. Neme end Address of Fecility			lity				
	Depa Impo	any Ronald	Board,	655 W	. Balti	more	Street				
-	-	23e Pert1. Enter the disease, or cor	mplications that caused the dea		Baltimon		21201 s cardiac or r	espiretory erro	est.	-	Approximete Intervel Between
Physician /Medical Examiner	/Medical	23e Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Interval Be Onset and Immediate Cause (Final disease or condition resulting in deeth) Arteriosclerotic Cardiovascular Disease e.								Onset end Deeth	
	<u> </u>		Due to (or es e consequence of):								
'n	earn cermicate be executed etherholing physician and for use as the burial-transit clan/Medical Examiner		b. Due to	Due to (or es e consequence of):							
200	iding physicialise as the bur	thet initieted events resulting in deeth) Lest	C. Due to (or as e consequence of):								
X00	of the clean centre of the by the ettending letached for use a Physician/M		d								
. 1	he etter hed for u	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause of death?			
S, P.								1 🗆 Y	1 ☐ Yes 2 ☐ No 3 ☐ Probably Y ☐ Unkno		
cords	the tay requires to sate has been signed, page 2 should be of Completed by							24e. Wes e	n eutopsy	ava	re autopsy findings
ec	2 she								PECTION completion of death?		npletion of cause death?
E 3	ite ha							10 W	e ZXXo	1□	Yes XX No
	ertifica ector, I										
	I direct	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatio	ent 3 DOA	Other: 4 N	lursing Home	5 Reside	nce 6 VX th	er (Specify	SCENE
IVISION OF	eth. r: After the funeral	27. Menner of Deeth XX Neturel 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Day Year) 28b. Time of Sec. Injury at Work? Injury M 1 Yes 2 No				28d. Describe how Injury occurred				
SIAID	of or Attending residence of Director: After the funer field in by the funer Certification:	3 Suicide 6 Could not determined	be d 28e. Plece of Injury - At home, ferm, street, fectory, off building, etc. (Specify)			ffice	28f. Location (Street and Number or Rural Route Number, City or Town, State)			Route Number,	
	in 24 hours he Funere pletely fille edical C										
To the within To the comp					icense number 29d. Date signed (Month, Day, Year) JULY 27, 1999						
	CA	30. Name entieddres of person and Dixon M. D.	mpleted ceuse of death (Ite 111	m 23e) (Type Penn	Street	, Baltir	nore,	Maryla	nd 2120)1	
	State Registrar	31. Dete filed (Month, Day, Year) JUL 2 8 1	999 32. Registrer's Slgr	neture	4. Ap.	alle					
						4-0		_			

Registrar DHMH 16 Rev 6/95



Physician /Medical Examiner **Funeral** Director the Maryland 10e State x 28a-f shows a notified at Director

Funeral

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Completed

Be

72 hours after death with

Emmadina

7 is marked other than "natural", or items 23a or traumatic event, the Maxical Examiner months to

I Hygiena.

Pages 1 and 2 should be finent of Health and Mental Fint: If Item 27 Is marked of

altimore,

nt of Health a : If item 27 is or other trai

Department of Important: If any injury or

Physician /Medicai

Examiner

the bunal-tran

USB 88

signed by I

Deed

After this certificate has

s after dean.

**I Director: After two the functions of t

To the Hospital o within 24 hours aft To the Funeral DI completely filled in

funeral

filled in by

Attending Physician: or death.

ò

physician

The law requires that the death certificate be axecuted

P.O. Box 68760,

Division of Vital Records,

Physician/Medical Examiner

þ

Completed

Be

2

Certification:

Medical

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent'a Nema (First, Middla, Last) Emma A. Carriker 4a. Fecility Name (If not institution, giva street and number) Doctors Hospital 5. Sociel Sacurity Number 7. Age (In yrs. lest birthdey)

2. Dete of Deeth

3. Time of Deeth 2:10Am 1999 Juli 4b. City, Town, or Location of Death 4c. County of Deeth

Lanham

Prince Georges

If Undar 1 Yaar If Under 24 Hrs. Deys Months 1 □ M 2 X F Hours 578-28-6794

Yrs 94

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

8. Dete of Birth (Month, Dey, Year)
Aug. 13, 1904

9. Birthplece (S 9. Birthpiece (Steta or Foreign Country) Min.

Usuei Residence of Decedent 10b. County 10c. City. Town or Location

10d. Insida City Limits 1 Yas 2 No

Maryland Prince Georges New Carrollton 10f. Zip Code

10g. Citizen of What Country? U.S.A.

8313 Quentin Street

1 ☐ Nevar Married 2 Married

12. Wes Decedant Ever in U,S. Armed Forces? Yas 25 No If Yes, Give Yaar or Detes:

 Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 1 ☐ Yas 2 € No Specify:

14. Race - American Indian. Bleck, Whita, atc. Specify: white

3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed)

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

20784

16b. Kind of Business/Industry

Elamentery/Secondary (0-12)

College (1-4or 5+) Nurse Medical

17. Fathar's Neme (First, Middle, Last)

Edward Clements

18. Mother's Name (First, Middla, Maidan Sumame) Dora Anna Clements

Date

19a. Informant's Name/Relationship (Type, Print)

19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Coda)

Charles M. Carriker/spouse 20a. Method of Disposition

20b. Plece of Disposition (Name of cemetary, cremetory or other plece)

8313 Quentin Street, New Carrollton, MD 20784 20c. Location - City or Town, Stata

1 □ Burial 2 □ Cremation 3 □ Removal from State 4 X Donation 5 ☐ Other (Specify)

21. Signature of Funeral Sarvice Licensee Ronald S

22. Neme end Addrass of Facility

State Anatomy Board, 655 W. Baltimore Street

23e. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or haart failure. List only one cause on each line.

Wade

Baltimore, MD 21201

Immediete Ceuse (Fine diseese or condition resulting in deeth)

Due to (or es e consequence of):

arcinoma

2 months

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disaase or injury that inhibeted events resulting in daath) Last

Due to (or es e consequence of)

Dua to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

Bleeding

1 Yes 2 No 3 Probably 4 Unknown

24e. Wes an eutopsy performed?

24b. Were autopsy findings avellebla prior to completion of cause 1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify)

1 Yes 2 No

25. Was case referred to medical 1 Yes 2 No

27. Mennar of Deeth 5 Pending invastigation

28a. Dete of tnjury (Month, Dey Year)

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of 28c. Injury at Work?

28d. Dascribe how injury occurred

6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Naturel

2 Accident

3 ☐ Sulcide

1 Certifying Phyalclan: To the best of my knowledge, deeth occurred et the tima, date end plece, end due to the cause(s) and menner es stated.
2 Medicat Examiner: On the beals of examinetion and/or investigation, in my opinion, deeth occurred et the tima, date and plece, and due to the cause(s) and menner stated.

29b. Signature end title of certifier

29c. License number 22549

1 ☐ Yes 2 ☐ No

29d. Date eigned (Month, Dey, Year) July 13,19

30. Nema end eddress of person who complated cause of death (Item 23e) (Type, Print)

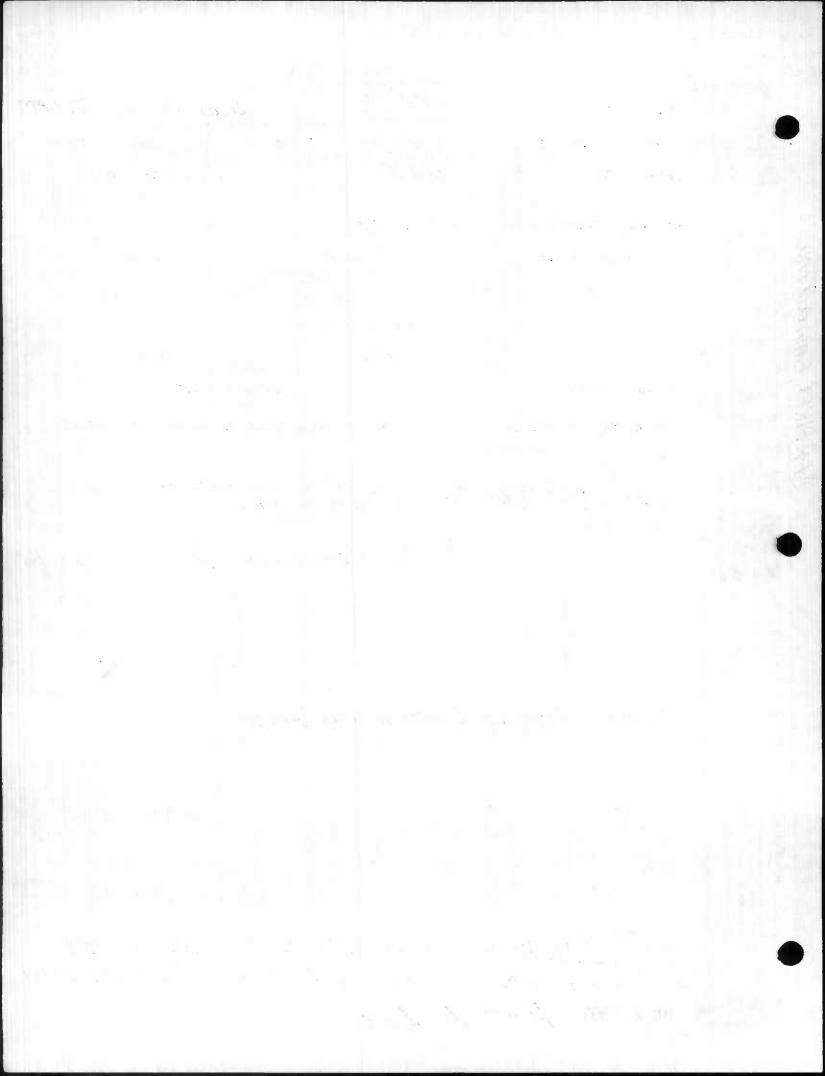
150 Kenilworth Ave Riverdale M.D. 20737 GHULAM MOHI-UD-DIN, M.D.

State Registrar

31. Date filed (Month, Day, Year)

JUL 2 8 1999

32. Registrar's Signeture

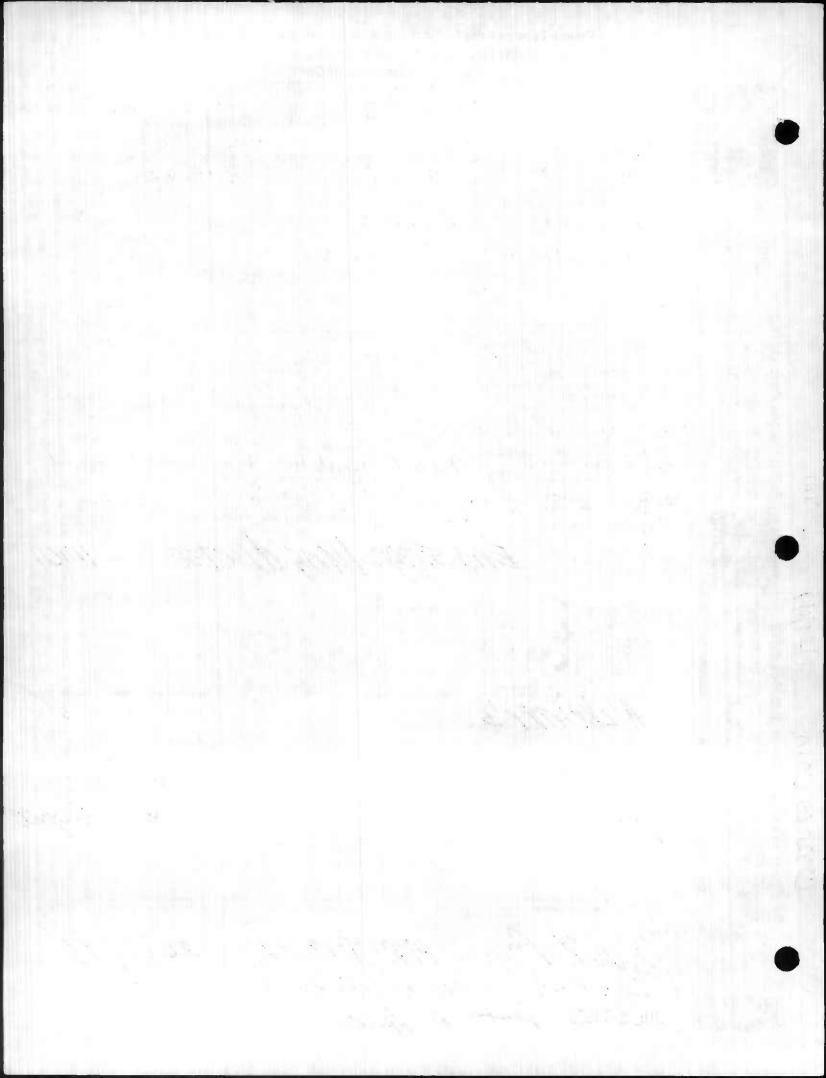


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** narles ain 2:40 p.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Richey Baltimore Joseph HOSPICE If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Åga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F Yrs. 217-09-4426 Director Usual Rasidence of Decedant r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Battimore 1 Vas 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7 ie marked other than "natural", or itema 23a or traumatic event, the Modical Examiner must be r V. Ellamont Funeral permit. Peges t end 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if flear 27 le marked other than "natural", or itema 23 any Injury or other traumatic event, the Medical Exercises many. 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Giva' Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 Yas 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada completed) Developers Collega (1-4or 5+) Elementary/Secondary (0-12) Improver 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cain Cain William 100salee 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 31 Ellamont Patterson-Baltimore, Md 21216 N. Daughter 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Data 1 Bufial 2 Cremation 3 Removal trop Stata
4 Conation 5 Other (Specify) Randallstown Park Memorial 7-30-99 22. Name and Addrass of Facility 21. Signature of Funeral Service | ce 1300 Wabasi guenue t ... Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, sk or heart failure. List only one cause on each lin . Approximate Interval Batween Onsat end Death 23a, Parti **Physician** /Medical Immediate Cause (Final disaasa or condition rasulting in daath) **Examiner** Examiner attending physicien and for use as the bunal-transit Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disease or Injury that Initiated evants rasulting in daeth) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a'consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of degli 1 ☐ Yes 2 ☐ No 3 Probably PV 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy 1 Yas 2 W 1 Yes 2 No 25. Was case raterred to medical axaminer? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Dother (Specify) 1 Yas EUNO Medicai Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of 5 Panding Invastigation 1 Netural 1 ☐ Yas 2 ☐ No or Attendiation of the description of the other death 2 Accident 6 Could not be detarmined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Sulcide 28t. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, tactory, office building, atc. (Specify) 4 Homicide 1 Certifying Phyaician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.
2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) end mannar stated. 29a. Cartifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number 32. Registrar's State 2 8 1999

Registrar

Moh

DHMH 16 Rev 6/95



Completed by Be Medical Certification: To

certificate

this

Affer

To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A

death. the

funeral director,

filled in by

Division of Vital Attending Physicien:

25. Was case referred to medical 2

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 26. Place of Death (Check only one)

2 No

examiner? 1 to Yes 2 □ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	ADD DOA	Other: 4 Nursing H	lome 5 Residence	6 Other
7. Manner of Death 1 ☑ Naturel 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	28d. Describe how in	ury occurred

6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and menner steted. one)

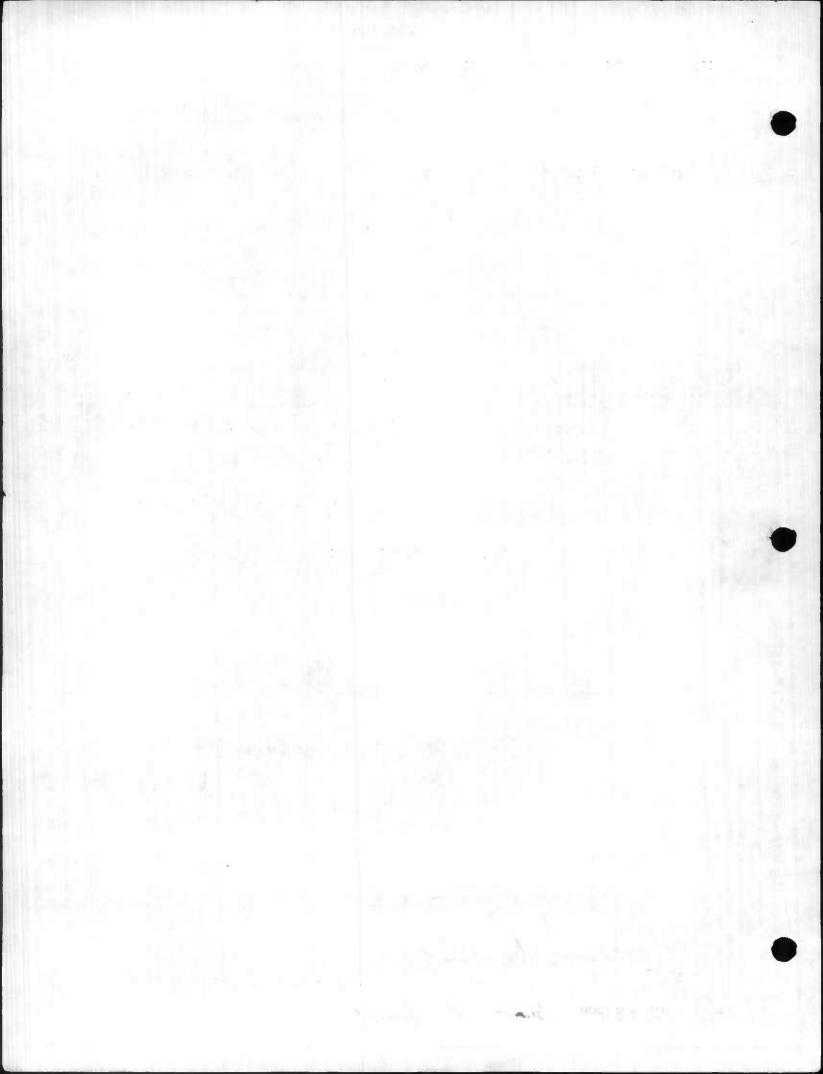
29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signa O.C.M.E JULY 26,1999

nd address of person who completed cause of de eath (Item 23a) (Type, Print) Ron

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date liled (Month, Day, Year) JUL 2 8 1999

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 23695 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Month **Physician** HOWARN CHOE 26 12:45 PN /Medical 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner A L If Under Months THE JOHA

5. Social Security Number 7. Age (In y/s. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** Days 180 M 20 F Hours 215-76-5903 1934 N. Korea 64 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Director Md. Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 4 Hampston Garth Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene. Important: if itam 27 is marked other than "natural", or item any injury or other traumatic avant, the Medical Exercipes ORGS. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Management Computer 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jon-Bin Choe Yun-Hwa Kim 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Yonga Mun Choe/wife 4 Hampston Garth Lutherville, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/30/99 Dulaney Valley Memorial Timonium. Md. 22 Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signatore of Euneral Service License 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner to (or as a consequence of): Examiner ician and burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s s the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 98 USB. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Records. þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending Investigation After 1 Neturai 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the To the 29d. Date aigned (Month, Day, Year) 29b. Signature and little of certific 29c. License number (Hom 23a) (Type, Print) LOO N. Wolfe St., Baltimore, MD 21289 trattini, Takes Hopkins
32. Registrar's Signature L 31. Date filed (Month, Day, Year) State JUL 28 1999

DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Christina Dena Cowman 4a. Facility Nama (If not Institution, give street and number) [6600 Ridge Rd. 4b. City, Town, or Location of Death 4c. County of Death BALTIMURE MB. 2/237 MANOR Baltimore ARC BAHIMORC Undar 24 Hrs. 5. Sociel Security Number 8. Dete of Birth Month, Dey Sear) Sept. 3, 1911 6 Sex 7. Age (In yrs. lest birthday) 9. Birthplace (Steta or Foreign Country) Italy 1 M 2 K Months Deys 87 219-16-9455 Yrs Usuel Rasidence of Decedent 10a Stete 10h Counts 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Baltimore 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Coda 10g, Citizan of What Country? 2994 Yorkway 21222 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No Wes Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - America Indian, Bieck, White, atc. 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: If Yas, Give Year or Detas: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) Collage (1-4or 5+) Homemaker Housewife 17. Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Flora Fortunati Valentino Larcher 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2994 Yorkway, Baltimore, Md. 21222 Perry O. Cowman - Husband 20b. Piece of Disposition (Name of cematery, cremetory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Metro Crematory July 30, 1999 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nama and Address of Facility Eckhardt Funeral Chapel 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately a such as cardiac or respiratory arrest, Approximately a such as cardiac or respiratory arrest, Approximate Interval Between Onset end Death fmmediate Ceuse (Final disaesa or condition rasulting in death) Sequentielly list conditions, if eny, laeding to immediate cause. Enter Underlying Ceuse (Diseesa or Injury that initiated events resulting in death) Last Precemonia Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? nalnu trition 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to complation of cause of deeth? 24e. Wes en autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes 25. Wes cese referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28e. Dete of Injury (Month, Dev Year) 28d. Describe how Injury occurred

The law requires that the death certificate be executed Box 68760. physician signed by the a Division of Vital Records, P.O. certificate has b irector, page 2 sl or Attending Physician: this Affer death.

by Completed

Physician/Medical Be 2 Medical Certification: Director: /

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

the Medical Examiner must be notified at

"natural".

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than ** and Injury or other traumetic event, the Med ORE.

Physician /Medical

Examiner

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72 hours after death with or Itams 23a or

Baltimore, Maryland 21215-0020

29e. Certifier (Check only one)

1i Neturel 2 Accident 3 Sulcida 4 Homlcide

29b. Signeture and title of certifiar

5 Pending Investigation

6 Could not be

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end manner steted. 29c. License number 5 48 271

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

Fahed ou 31. Dete filed (Month, Dey, Year)
JUL 2 8 1999

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7600 Oslan Dr. Touson, MD 21204

State Registrar

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within 24 hours of To the Funeral Di completely filled is Hospital

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10/a Duncan Julia 2300 1999 → /Medical 7. Aga (In yrs. last birthday)

Yrs.

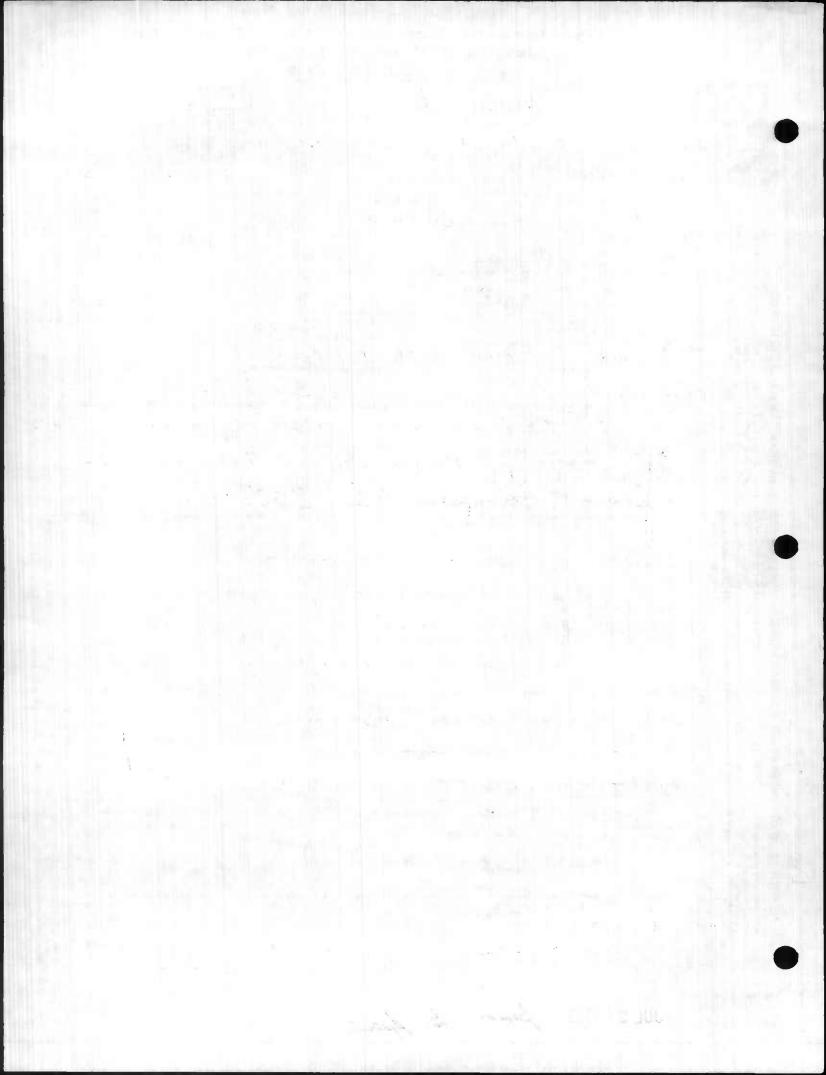
The property of the prop 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner He brew Geriatric Levindale 5. Social Security Number Birthplace (State or Foreign Country)
 C 10 M 25 F 220-20-2622 Director Usuel Residence of Decedent 10c. City, Town or Location 10a Stata 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, the Medical Examinal must be notified at Baltimore Ma NA 1 Yes 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21216 3402 ar liste Avenue permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23. Funeral 12. Wes Decedant Ever in U,S. Armed Forcas? 1 Yas 2 No If Yas, Give Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, atc. 1 Nevar Marriad 2 Married 1 ☐ Yas 2 No Specify: altimore, Maryland 21215-0020 Black þ 3 MWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Unit 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 755er 8th grade 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fethar's Neme (First, Middle, Last) Sallie Pe Hifora demes 19a, informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Stokes Daughte 3402 Cartisle Avenue Balto, Md 21216 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Data 20c. Location - City or Town, Stata 1 Surial 2 Cremetion 3 Ramovei from State
4 Donation 5 Other (Specify) any injury or 7-29-99 re of Funeral Service in ensee 22. Nama and Addrass of Facility Enter the disease, or complications that caused he deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, or heart fellura. List only one ceuse on each link. Approximate Intervel Between Onset end Death **Physician** /Medicai immediat Ceusa (Final disease or condition rasulting in daeth) Examiner Examiner Cormary aphysician and s the burial-trans Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiated evants resulting in deeth) Lest Sepsis Physician/Medical Due to (or es e consequence of): multiple Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, 9 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed 25. Was case referred to medical examiner? 1 Yes 2 No 1 ☐ Yes 2 ☐ No discuse or Attending Physician: funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 □ ER/Outpatient 3 □ DOA 24 hours after death.

Funersi Director: After this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred 1 Naturel 5 Panding 1 Yes 2 No invastigation 2 Accidant 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 Postifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifiar (Check only one) within 2 29b. Signetura end title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 2300 Consuel D:44907 CONSUELO LVME 30. Nama and addrass of person who completed ceusa of death (item 23a) (Type, Print) 2-, MD 32. Registrar's Signatura Belvedore 31. Deta tiled (Month, Dey, Year) State JUL 2 8 1999

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Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 1245 Pm Month VERBA DORSEY 12 July 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not Institution, give street end number) 2309 Chelsa Terrace Da timore H Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplace (State (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Birthplace (Month), Day, Year) 9. Bi 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2XF 213-16-2223 93 Yrs. Usuei Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Maryland Baltimore 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number U.S.A. 21216 2309 Chelsa Terrace 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Rece - American Indian. Bleck, White, atc. 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Datas: 1 Nevar Merried 2 Merried 1 Yas 2 No Specify: specify: black 3 No Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Own Home 8 Housewife 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Anna Lee Fitzgerald Charles Hubert Falden 19a. informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 3310 Tioga Parkway, Baltimore, MD 21215 Beatrice Broadway/guardian 20b. Place of Disposition (Neme of cematary, crametory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 Donation 5 Othar (Specify) 21. Sig ... a of Fun al Service Licensee 22. Neme and Addrass of Facility State Anatomy Board, 655 W. Baltimore Street Wade Tonald S. *ector Baltimore, MD 21201

3a. Part, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, ahoc, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onsat end Deeth immediata Causa (Final disaasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. M. Hairegurgitation 1 Yes 2 No 3 Probably 4 Unknown Renal insufficiency 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? TU Yes 2 Nic 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Nothar (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28b. Time of 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 □ Yes 2 □ No

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that the deeth certificate be executed P.O. Box 68760. Division of Vital Records, The law requires Physician:

To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the Iuneral

State Registrar

27. Mannar of Death 1 Dolaturai

2 Accidant 3 Sulcide 4 - Homicida

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28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

> Medical Menoina

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 7/20 199

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

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31. Data filad (Month, Day, Year)

29b. Signature and title of cer

8 1999

32. Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death

3699 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Dav Month Year **Physician** CHARLES DILLON 1250 g.M 26, 1999 DULY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** tos pital HODKINST Itimore Johns If Under 24 Hrs. ff Under 1 Yeer 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F 428-26-3833 89 Director Miss Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23s or 28s-f shore Examiner must be notified at 1 Yas 2 No Harford Director Md. Havre De Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 2147 Sherwood Lane U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forcas? 14. Race - American Indian, 11 Marital Status Black, Whita, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married 21215-0020 Specity: Black 1 ☐ Yas 2 X No Specify: þ 3€Widowed 4 □ Divorced Year or Dates: Be Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Taxi Driver Transportation Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked oth jury or other treumatic even Ellis Dillon Ora Dillon 19b. Meiling Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baryy Zevin Dillon/Son 2147 Sherwood Ln. Havre De Grace, Md. 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or Harford Memorial Gardens 7/30/99 Harford Co., Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility William C. Brown Community F/H Harford, P.A. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart tellure. List only or cause on each line. 21001 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner MEDING CHOLANGITIS burial-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated eventa resulting in death) Last Due to (or as a consequence of) physician s the buria Box 68760. Physician/Medical Due to (or as a consequence of): 80 signed by the attending to be detached for use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Ho 3 Probably 4 Unknown CANCER Completed by Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 4 0 1 Yes 2 TWO certificate Division of Vital funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 24 hours efter death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 - Homicide Hospital 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) within 2 the th 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifiar W TES-000

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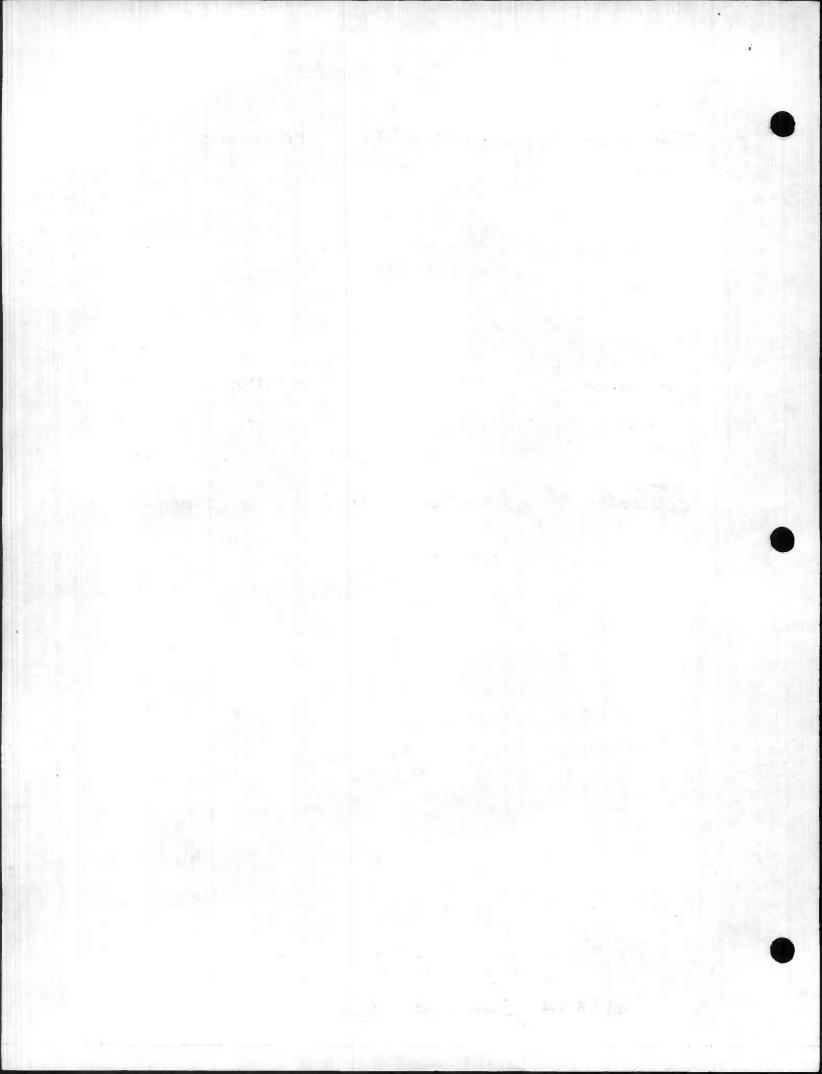
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1D GOON. Wolfe St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 2 3 7 0 0

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State

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 8 1999

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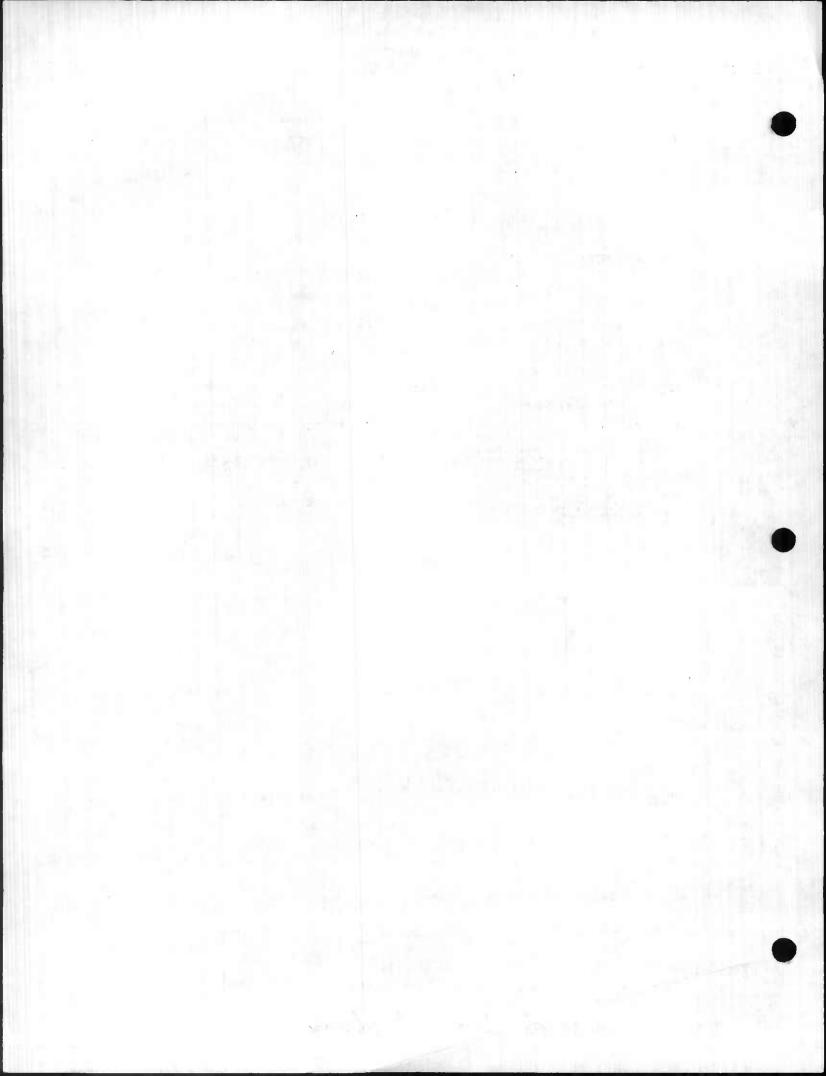
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ARTHUR ERNEST ESZES, SR. Month Day Year Julia Ju	TENS.	: #6 PER F.H. G773 7/30/99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death									Reg. No.		2 Tim	ne of Dooth
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29e. Certifier (Check only one) 29m Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 7/26/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			ZOO. PIECE OF	Injury - At h etc. (Speci	ome, ferm, atr fy)	eet, fact	ory, office			28f. Location (City or To	(Street end Nu wn, State)	mber or I	Rural Route	Number,
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ate 31. Dete filed (Month, Day, Year) 32. Registrar's Signature		31 Date filed (Month Day Year)	32. Regi	strar's Sign	ature									

DHMH 16 Rav 6/95

JUL 28 1999

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Hazel M. Everett July 25, 1999 7:50a.m. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 712 N. Gilmore Street # Under 1 Year If Under 24 Hrs. 5. Socief Security Number 7. Age (In vrs. last birthdev) Birthplaca (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) Deys Hours Months 1□M 2□F 212-22-5618 84 Yrs April 11, 1915 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore Md. XX Yes 2 □ No 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 712 N. Gilmore Street 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: Black 3⊟Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Shoe Salesperson Shoe Companies 11th Grade 17. Father's Neme (First, Middle, Last)
Joseph H. Yorkshire 18. Mother's Neme (First, Middle, Maiden Surneme) Mary V. Young 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) son Thomas X. Yorkshire 712 N. Gilmore Street Baltimore, Md. 21217 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete
4 ☐ Donetion 5 ☐ Other (Specify) July 30 Baltimore, Md. New Cathedral Cemetery 21. Signatu of Funeral S Licens 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 2 23a. Part. Enter the disease, or comitications that it used the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause in each line. Approximete Interval Between Onset and Deeth MYOCARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in deeth) IMMEDIATE Due to (or es a consequence of): ASCVD-CHF YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? SEVERE OSTEO ARTHRITIC KNEES 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 No 28a. Deta of Injury (Month, Dey Year) r of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not determed 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the fime, date end plece, and due to the cause(s) and manner as stated.

The law requires that the death certificate be assected Box 68760, P.O. of Vital Records, Attending Physician: Division To the Hospital or Attand within 24 hours after deatl To the Funeral Director:

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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Be Completed

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Department of Important: If any Injury or

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edical Certification: To

Examiner

Baltimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

(Check only one)

31. Date filed (Month, Dey, Year)
JUL 28 1999

29b. Signeture and title of certifier

Louis N. Randall MD 2300 Garrison BLVD. Baltimore, Md. 21216 32. Registrer's signetura

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

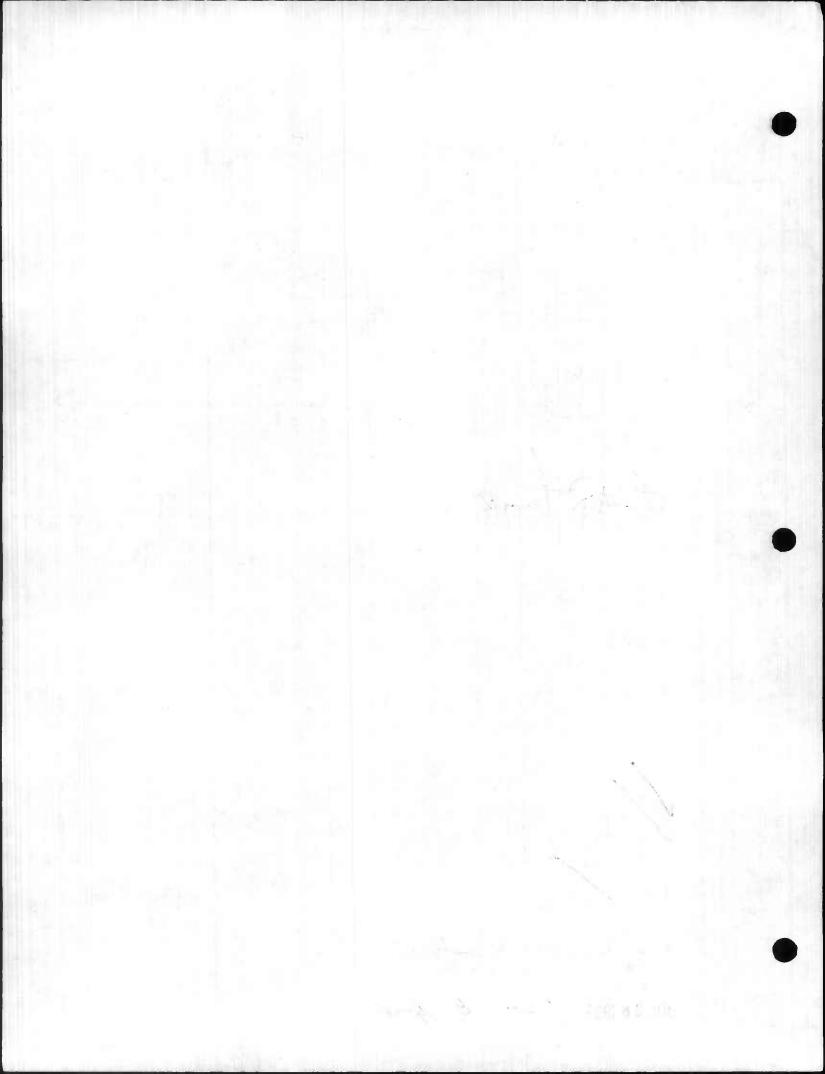
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

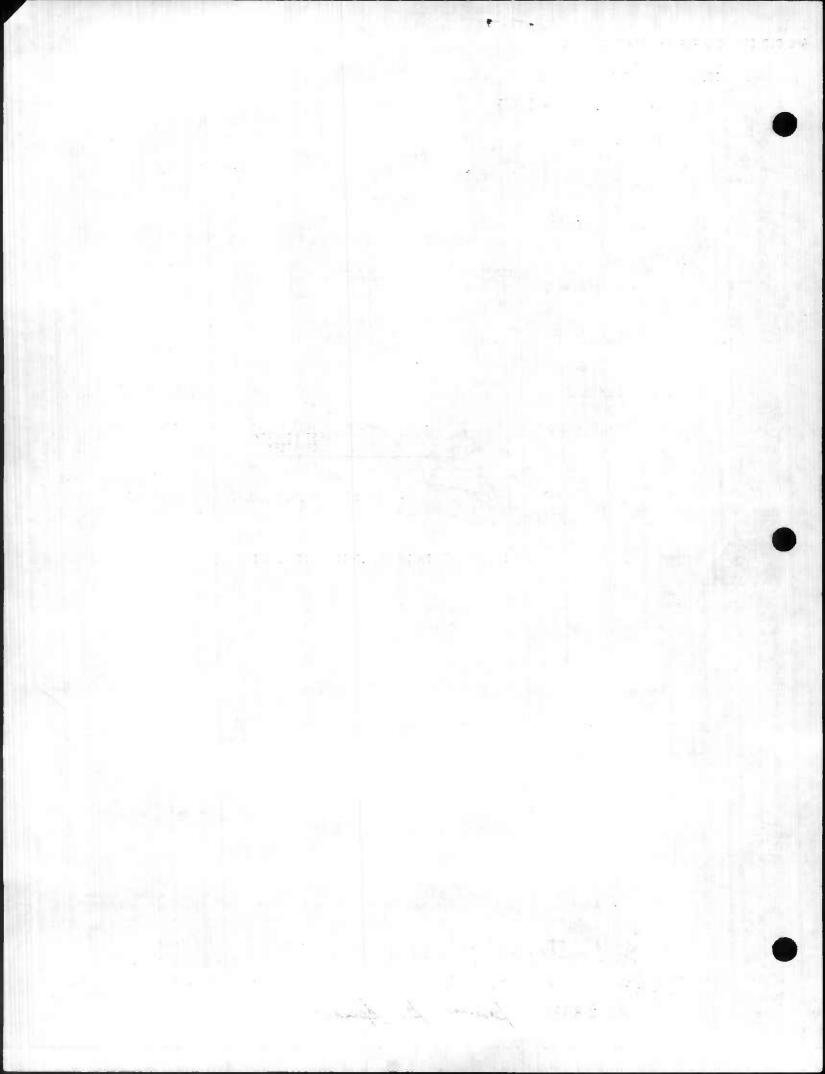
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29c. License number

29d. Date signed (Month, Dey, Year)

July 27, 1999





99-4350-510

Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible.

EDWARD

State of Maryland / Department of Health and Mental Hygie

Days

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	Physician
	/Medical
)	Examiner

HEMBY AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G773 Certificate of Death 1. Decedent's Name (First, Middle, Last) **EDWARD** EARL HEMBY

2. Dete of Death Month JULY 23,1999 3. Time of Deeth 10:08P.M.

Funeral Director

618 POPLAR GROVE STREET 5. Sociel Security Number 213-72-9970

4e Facility Name (If not institution, give street and number)

If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Months 42

4b. City, Town, or Location of Death BALTIMORE

4c. County of Deeth

Usual Residence of Decedent 10b. County Yrs.

Date of Birth (Month, Dey, Year) 9-13-1956 Hours

9. Birthplece (State or Foreign Country) Md

r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at

Director

Funeral

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Completed

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Examiner

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Certification: To

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Hygiene.

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permit. Page Department of Important: If any Injury or once.

Physician

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page 2

certificate

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24 hours after deat Funeral Director:

To the F within 2

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completely

that the death certificate be executed

requires been sig

The law

Attending Physician:

ò

Hospital

Box 68760

altimore, Maryland 21215-0020

Md N/A 10c. City, Town or Location Baltimore

10d. Inside City Limits

1XXYes 2 No

10e. Street and Number

Road

10f. Zip Code 21216

10g. Citizen of What Country? USA

931 N. Franklintown 11. Meritel Stetus

1X Never Merried ·2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2XNo Specify:

14. Race - American Indian, Bieck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) G E D

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry Unk

17. Father's Neme (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame)

Myrtle Hemby

Blue Edward

19a. Informant's Name/Relationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Myrtle Hemby - Mother 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

Various

931 N. Franklintown Road Baltimore, Md 21216 Date 20c. Location - City or Town, Stete

1 Dourial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify)

King Memorial Park

7-29-99 Randallstown, Md

Signature of Funeral Service Licens Rome

22. Name and Address of Facility
March F/H West

4300 Wabash Avenue Baltimore, Md 21215 Enter the disease, or complications that caused the rienth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heen failure. List only one cause on each line. Approximate Interval Between Onset and Deeth

Immediate suse (Final disease or condition resulting in deeth)

23a. Pert1

ACUTE COCAINE AND NARCOTIC INTOXICATION

myper

Due to (or es a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or es a consequence of):

1 Yaa 2 No 3 Probably ₩ Unknown

23b. Did tobacco use contribute to the cause of death?

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 Nes 2 No 26. Place of Death (Check only one)

1 Yes 2 No

25. Was case referred to medical NOXYes 2 No 27. Manner of Death

1 Netural

2 Accident

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

Jenn

5 Pending investigation 6 Could not be determined 28a. Date of Injury Fou(Month, Day Year) 7-23-99

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28b. Time of Found? 9:39

Other: 4 Nursing Home 5 Residence 6 Y Other (Specify) C.F.N.E. 28c. Injury et Work? P 1 Yes 2 No

28d. Describe how injury occurred UNKNOWN

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) FOUND IN VACANT HOUSE

1 Inpatient 2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Boute Number, City or Town, State) 618 POPLAR GROVE STREET BALTIMORE, MARYLAND

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certified

Chut

29c. License number O.C.M.E.

JULY 24, 1999

29d. Dete signed (Month, Day, Year)

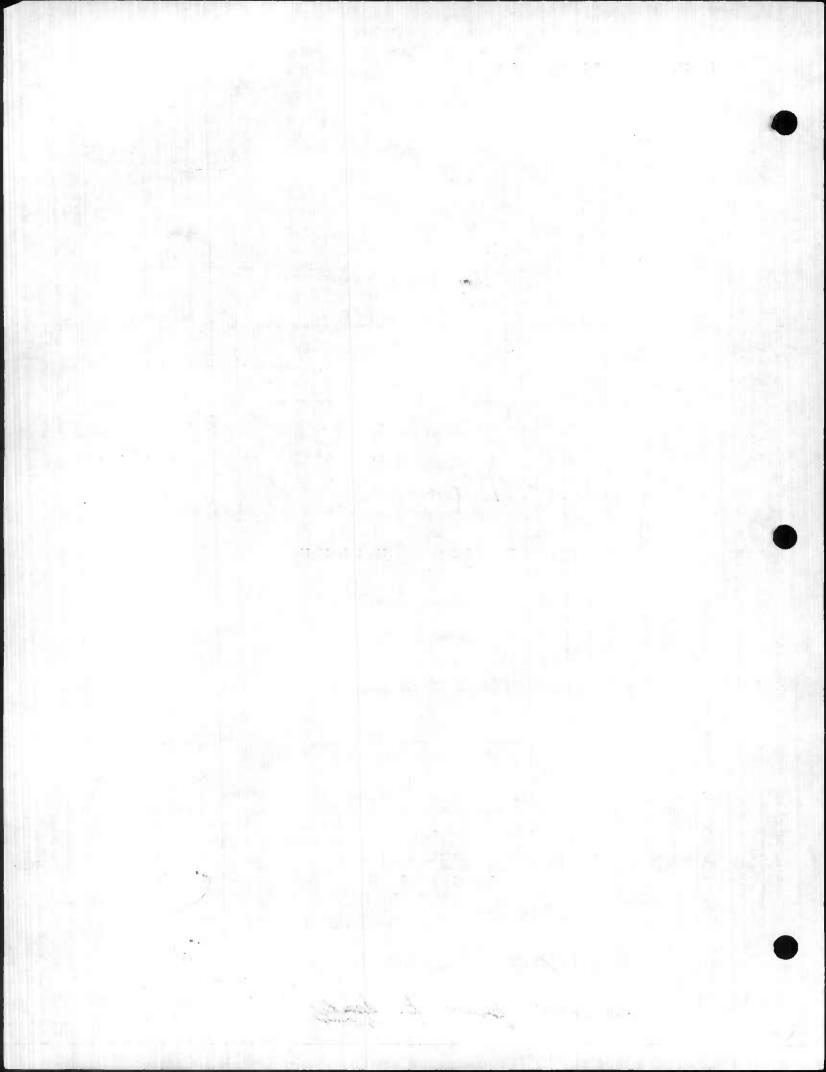
completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) JUL 2 8 1999 32. Registrar's Signature

DHMH 16 Ray 6/99

P.O. Records. Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Mary 1021 elen Henson 24 0 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Agnes Hospital 900 S. Couton Ave Boutimas # Under 1 Year | # Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 8 Yrs. 5. Social Security Number Birthplace (State or Foreign Country) 10 M 20 F 217-07-562 Usual Residence of Deceden 10s. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NA Md Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road U.S.A 021 Wicklow 21229 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Marital Status Black, White, etc. 1 Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) aundry Elementary/Secondary (0-12) College (1-4or 5+) Worker haundry 120 grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henson arne Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shinley Road 1021 Widdow Ba Ho, nd 21229 Gardner Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bulial 2 Cremetion 3 Remove from State 4 Donation 5 Other (Specify) Do dlawn 7-30-99 en et ery 21. To at of Funeral Service 22. Name and Address of Facility F.H. Wast Wabash Kumpsin Da Ho, Md 21215 Lome 300 Avenue 23a. Per f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG MONTH CANLER Due to (or as a consequence of) DISEASE CHRONIC OBSTRUCTIVE LUNG 10 YEAR ! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 140 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Dinpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 DNaturat 5 Pending investigation 1 Tyes 2 No 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Yown, State)

29d. Date signed (Month, Day, Year)

physician and the burlel-transit this or Attending

Physician

/Medical

Examiner

Funeral

Director

288-f show

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Nerna 23a

permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or hen eny injury or other treumatic event, the Medical Exemina-

Physician /Medical

Examiner

Examine

Physician/Medical

Š

Completed

89

Medical Certification: To

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

Baitimore, Maryland 21215-0020

Director

Funeral

à

Completed

the Meryland

24 hours efter deeth. To the Hosp within 24 ho To the Fune completely fi

State Registrar **DHMH 16 Rev 6/95**

31. Date liled (Month, Day, Year) JUL 8 8 1989

6 Could not be

AKS=NTI JEVICH 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

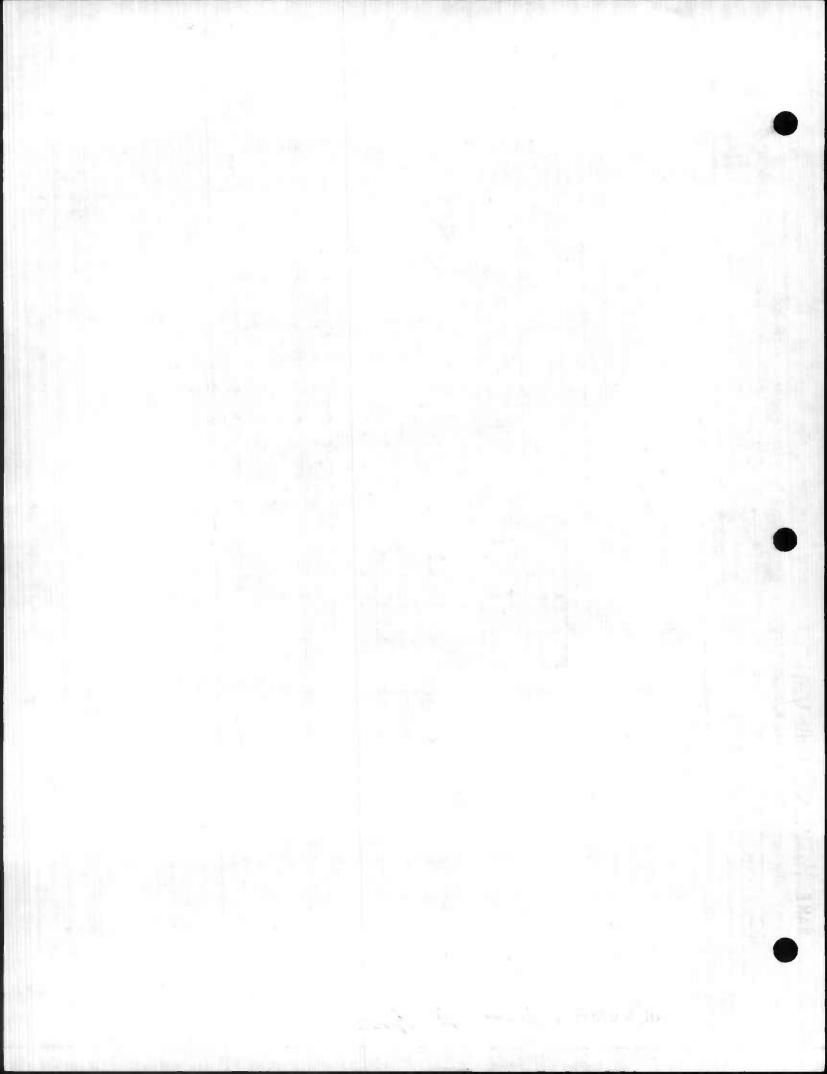
00

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

CATON AVENUE

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev **Physician** 26, JOHN GILBERT HARMAN 1999 07:00 P.M. July /Medical 4e Fecliity Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Elkridge 6391 Rowanberry Dr. Apt. 106 Howard 8. Date of Birth (Month, Day, Yeer) Feb. 5, 1 5. Sociei Security Number 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex **Funeral** 1. M 2□ F Deys Months Hours Yrs. 213 28 3084 72 1927 Maryland Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiena.
Int: If Item 27 is marked other than "natural", or items 23s or 28s-f show any or other traumetic avent, the Medical Evanther must be notified at 10c. City, Town or Location 10e State 10h Counts 10d. Inside City Limits 1 ☐ Yes 2X No Director Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6391 Rowanberry Dr. Apt. 106 21075 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: white 1 Yes 2€XNo Specify: þ 3 ☐ Widowed 4 🎖 Divorced Completed 15. Decedent's Education 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Service/Sales Auto Parts 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) 86 Gilbert Edwin Harman Edna Mae Newman 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Tracie Harman Reilly (daughter) 6141 Hunt Club Rd., Elkridge, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Mathod of Disposition 1 X Burlei 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or page. 4 ☐ Donetion 5 ☐ Othar (Specify) Columbia Memorial Park 7/30/99 Clarksville, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge Mem. Pk.,7250 Wash. Blvd.,Elkridge,MD 23e. Pent Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Deeth **Physician** · CHRONIC OBSTRUCTIVE PHLMONARY DISGASE /Medical Immediate Cause (Fine) disease or condition resulting in deeth) Examiner Examiner CONRESTIVE physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disaasa or injury that initieted events resulting in death) Lest Physician/Medical Due to (or es e consequance of): use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the s should be detached 1 (NYes 2 No 3 Probably 4 Unknown ATHEROSCLEROSIS OF AONTA þ 24b. Were eutopsy findings evallable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy s certificate has t 1 Yes 2 No 1 Yes 2 No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica tuneral director, 25. Was case referred to medical exeminer? 8 26. Piece of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28e. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D completely filled 1 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at tha tima, data end place, and due to tha cause(s) and menner stetad. 29a, Certifier edicai

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

State Registrar 31. Dete filed (Month, Dey, Year) JUL 2 8 1999 Main St., Elkridge, Md. 32. Registrer's Signeture

29b. Signeture and title of certifier Soon JA Kim, M.D.

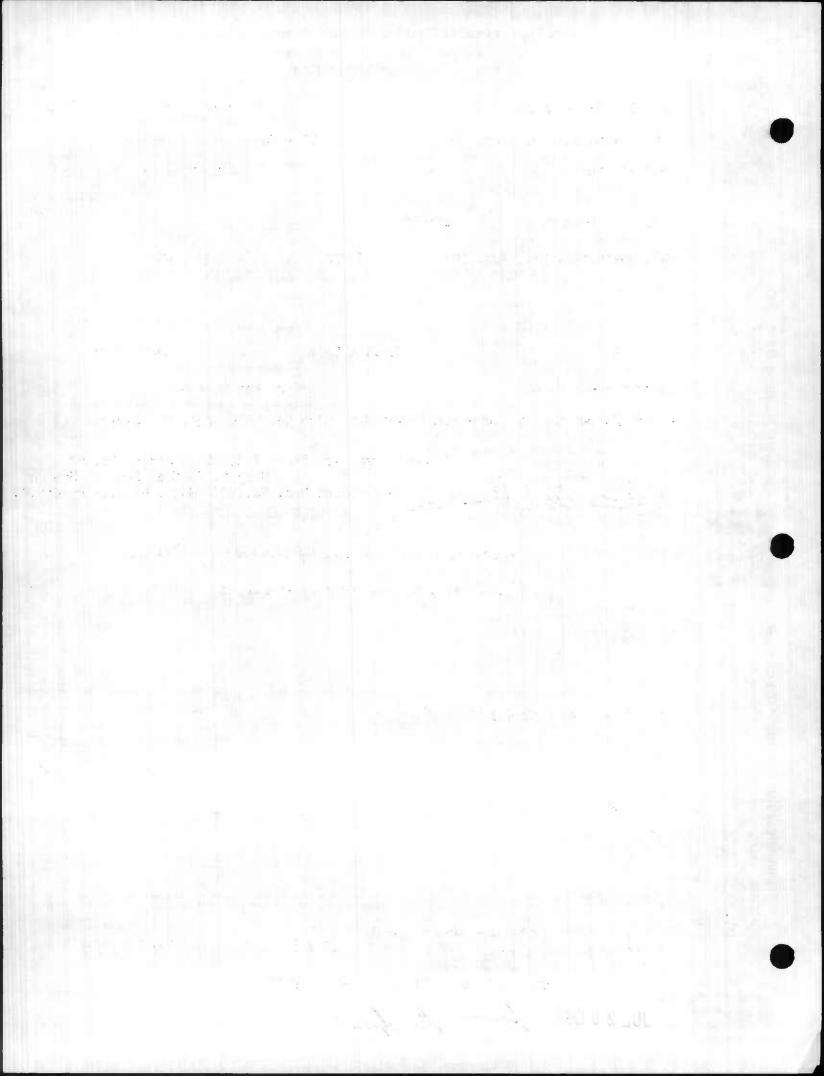
lui , ms 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Sports

29c. License number

D 72832

29d. Date signed (Month, Day, Year)



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Month** 12: 40 P.M T July 4b. City, Town, or Location of Death HIINT GORDON 4a Facility Name (If not institution, give street and number) 4c. County of Death North Arundel Anne Arunde Burnie Hospital Glen If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) NEW YORK 5. Social Security Number 6. Sex Days 1X M 2□ F 90 Yrs. FEB. 5, 076-09-4549 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NEW YORK CHEMUNG ELMIRA 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 608 GROVE STREET 14901 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 11 Morital Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried WHITE 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry AUTO & AVIATOR Elementary/Secondary (0-12) College (1-4or 5+) 2 MACHINIST INDUSTRY 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Meiden Sumame) HUNT BELLE **EVANS** CHARLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) RET. BRIG. GEN. JAMES W. HUNT 216 WINCHESTER COURT, ANNAPOLIS, MD. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete tery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State HILLCREST CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 17/29/99 DE RUYTER, NEW YORK 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Heckeul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. HEMON HACE Immediata Cause (Finel CASTRO-INTESTINAL disease or condition resulting in death) Sequentially its conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) 23b. Did tobacco use/contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NZ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

1 Yes 2 No

Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner steted.

29c. License numbe

Examiner The law requires that the desth certificate be executed physician and the burief-transit Physician/Medical 280 0 deteched signed by t d be detect à should Completed i cartificata hes b director 8 Certification: To this funeral After

Physician

/Medical

Examiner

Director

by

Completed

8

Funeral

Director

Pages 1 and 2 should be filled within 72 hours after death with the Menyland nent of Health and Mental Hyglene.
Instit if item 27 is marked other than "natural", or items 23s or 28s4 show my or other transmit or items 25s or 28s4 show my or other transmit be notified at my or other transmit be notified at

pemit. Page Department of Important: If eny injury or once.

Physician

/Medical

Examiner

Baitimore, Maryland 21215-0020

TOR DON

Box 68760. P.O. Records. Division of Vitai or Attanding Physician: n 24 hours efter death.

Ne Funeral Director: After plately filled in by the fun Hospital To the Fune completely fi

within 2

DHMH 16 Rev 6/95

State Registrar

edical

JUL 28 1999

5 Pending

investigation

the ung

6 Could not be

1 Natural

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifie

32. Registrar's Sig

M

301

Name and address of person who completed cause of death (Item 23a) (Type, Print)

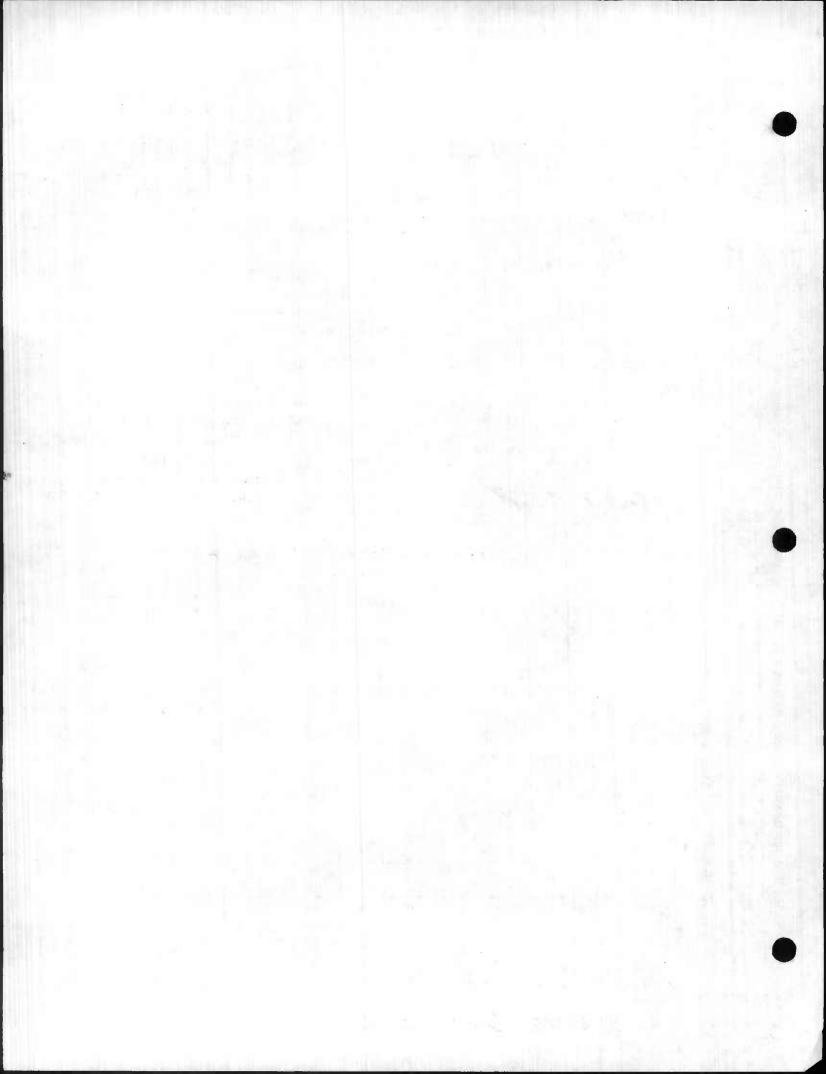
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

ORIGINAL

29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Busnie, no. 21061.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Hayden ouise 2-30 Am Jul 1999 24 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Liberty Medical Center Baltimore n/a 8. Date of Birth (Month, Day, Year) May 30, 1921 5. Social Security Number 220-09-6702 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday). 9. Birthplace (State or Foreign Country)
Md. **Funeral** Days Months Hours 1 ■ M 2 XX Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or frame 23s or 28s-f show the Medical Examiner must be noticed at Md. n/a Baltimore 1XX es 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21216 4008 Clifton Avenue Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Mantal Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Black P 3⊟Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if item 27 is marked other than nationy or other traumatic avent, the Medical page. 15. Decedent's Education (Specify only highest grada completed) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration Module Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elvira Briscoe Alfred F. Jackson 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Gilbert R. Jackson 8122 Streamwood Drive Pikesville, Md. 21208 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Garrison Forrest VeteransJuly 29 Owings Mills, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part 1. Enter the disease, or complications if at a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate triterval Between Onset and Death Physician Immediata Cause (Final diseasa or condition resulting in death) /Medical SEPSIS Examiner Due to (or as a consequence of): Renal FATLURE. END-STAVE Examine physician and s the buriel-transit Due to (or as a consequence of): nternal Breeking Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last CHASTRO -Physician/Medical Due to (or as a consequence of): Respirator 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Encephaloputho. 1 Yes 2 No 3 Probably 4 Onknown Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by edical 29a. Certifier 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

that the death certificate be asseuted P.O. Records, of Vital i or Attending P after death. I Director: After d in by the funer Division

certificata

this

After

Box 68760.

72 hours efter

"natural".

Baltimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

JUL 2 8 1999

R. M SHAH NO

R-~ Szar~

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signeture and title of certifier

31. Date filed (Month, Day, Year)

2500 32. Registrar's Signature

CINERTY LA AVE Balhmere, ND.

19608

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middle, Last) 3. Time of Death RICHARD LEO JUDGE 26. 1999 4b. City, Town, or Location of Death 02:26 AM 4c. County of Death 4a Facility Nama (If not institution, giva street and number) St. Agnes Hospital, Wilkens & Caton Aves. N/A Baltimore If Undar 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Days Hours Min 1♥M 2□F 217 24 2632 70 Feb. 12, 1929 Maryland Usual Rasidance of Dacedant 10e. Stete 10b. Count 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas XX No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Coda 9806 Michaels Way 21042 USA 14. Raca - American Indien. 12. Was Decedant Evar in U,S Armed Forcas? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, Whita, etc. 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 1 ☐ Never Merried 2 Merried 1 Yas 2 No Specify 3 Widowed 4 Divorced white 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elamantery/Secondary (0-12) Collega (1-4or 5+) Heidelman Brewery 9 machinist 18. Mothar's Nama (First, Middle, Maidan Sumeme) 17. Fether's Neme (First, Middla, Last) George Judge, Sr. Marie Obrender 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Catherine B. Judge 9806 Michaels Way, Ellicott City, MD (wife) 21042 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gardens 7/30/99 Marriotsville, MD 21. Signatura of Funarai Sarvice Licensee 22. Nama and Addrass of Fecility Gary L. Kaufman Funeral Home @ Meadowridge Mem. Pk., 7250 Wash. Blvd. Elkridge, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate intarval Between Onset and Death Immediata Cause (Finel disaase or condition rasulting In daath) ASPIRATION PNEUMONITIS, ACUTE 2-3 Hours Dua to (or as a consequence of): FLUID DISTENTION OF STOMACH 1-2 Days Saquantielly list conditions, if any, laading to immadiata cause. Enter Underlying Cousa (Diseasa or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of) STATUS POST SIGMOID RESECTION FOR CARCINOMA OF Dua to (or as a consequance of): COLON 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 R Yes 25. Was cesa refarred to medicel axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 3 1 Yas Inpatient 2 ER/Outpatient 3 DOA Menner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Matural 5 Panding 1 Yes 2 No investigation 2 Accidant 6 Could not be datarminad 3 Sulcida Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homlcida

physician and the burial-tran certificate be axed Box 68760, 88 esn signed by t peeu pege 2 s certificate

Physician

Examiner

Funeral

Director

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death

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Injury or permit. Page Department of Important: If any Injury or

Physician /Medical

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Pages 1 and 2 should be filed within 72 hours after inent of Heelth and Mental Hygiene. Int: If Hem 27 Is marked other then "naturel", or He

altimore, Maryland 21215-0020

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Division of Vital Records, P.O. Attending Physicien: After this death. efter deat Director: filled in by 6 24 hours e Hospital Vithin 2

RICHARD JUDGE

State Registrar

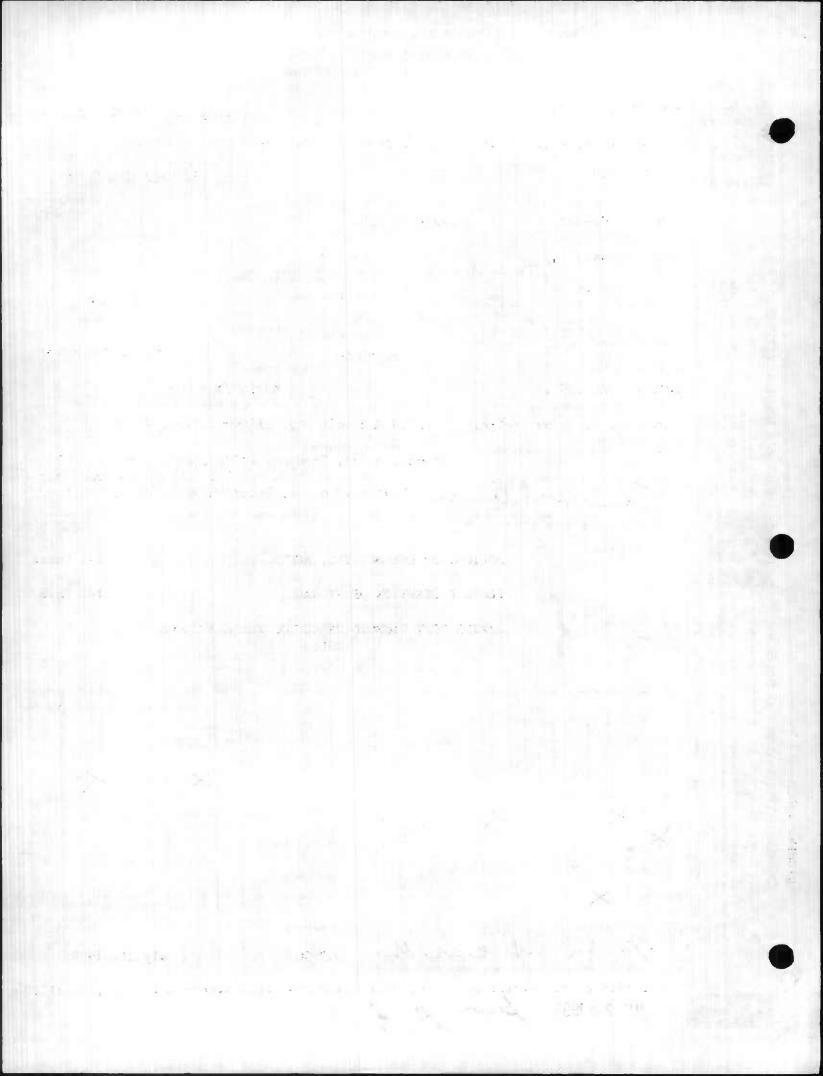
Cartifying Physician: To the bast of my knowledge, deeth occurred at the time, deta and place, and due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and titla of certified 29c. License number D09990 30. Neme and address of person who complated ceusa ordeath (Itam 23a) (Type, Print)

29d. Data signed (Month. Day, Year) July 26, 1999

Dr. Michael E. Pelczar St. Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229

2. Registrar's Signature 31. Data filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6:30 Pm Arthur July 23, B. Jenkins Jr. 1999 Facility Name (If not institution, give street and number) 209 N. Monastery Avenue 4b. City, Town, or Location of Death 4c. County of Death Baltimore n/a If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 12 M 2 F 55 219-40-3532 Jan. 29, 1944 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits n/a 1 No Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 N. Monastery Avenue 21229 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 You Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 € Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementery/Secondary (0-12) College (1-4or 5+) Public Schools Music Instructor 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Arthur B. Jenkins, Naomi Battle 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Arthur B. Jenkins III 4000 The Alameda Baltimore, Md. 21218 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State Arbutus Memorial Park July 28 Baltimore, Md. 4 ☐ Donstipn 5 ☐ Other (Specify) 21. Signatury of Funera e Lice see 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Er P it Enter the dilesse, or complication it it caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Intervel Between Onset and Deeth Immediate Csuse (Finsl disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disesse or injury that influence devents resulting in deeth) Last Due to (or es e co Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 200 1 ☐ Yes 2 No 26. Place of Death (Check only one)

68760 Box P.O. Records. **Physician**

/Medical

Examiner

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Item 27

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Physician

'/Medical Examiner

should be filed within 72 hours after death nd Mental Hygiene. marked other than "natural", or flama 23.

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21215-0020

Baltimore, Maryland

the Maryland

Examiner The law requires that the death certificate be executed physician s the buria Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. þ Certification: To Be Completed Dage 2 of Vitai Physician: 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 8 Other (Specify) 1 Yes 2 No After this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division or Attending 1 Netural 5 Pending 1 TYes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 8 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier completely (Check only To the ! 29c. License number

State Registrar

DHMH 16 Rev 6/95

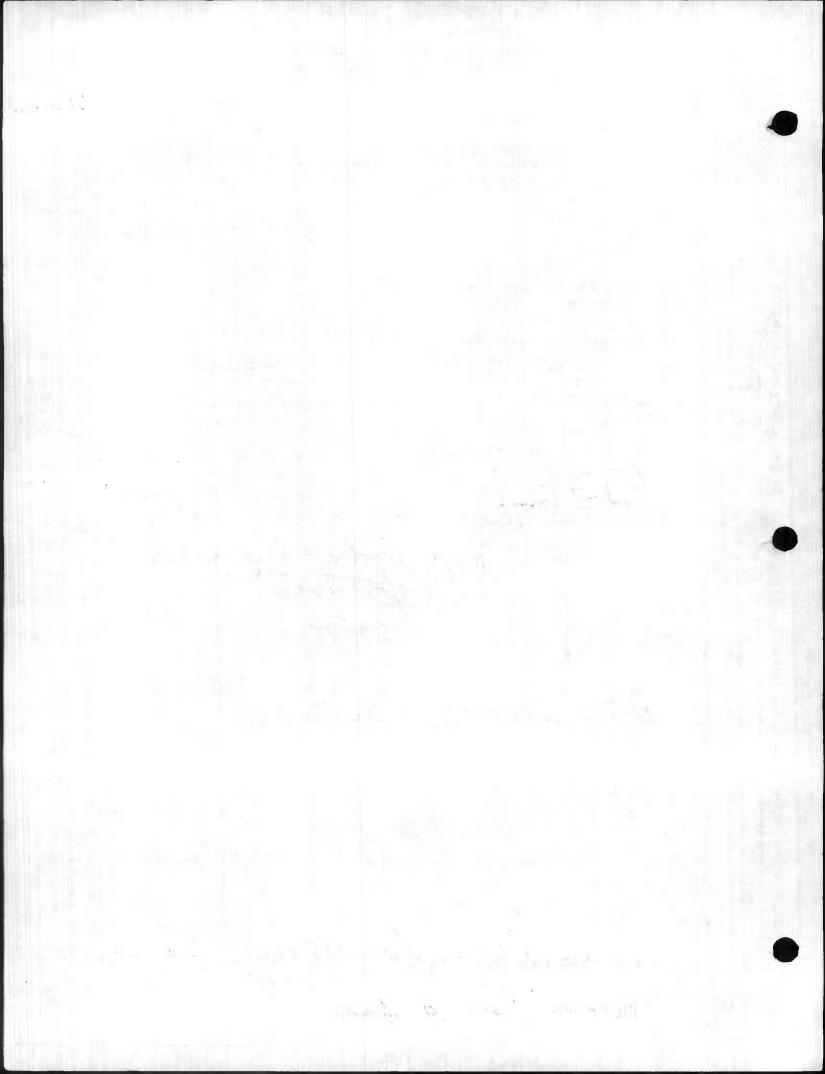
29b. Signeture and title of certifie

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JUL 28 1999 22. Registrar's Sign

ited cause of death (Item 2Ba) (Type, Print)

29d. Date signed (Month, Day, Year)



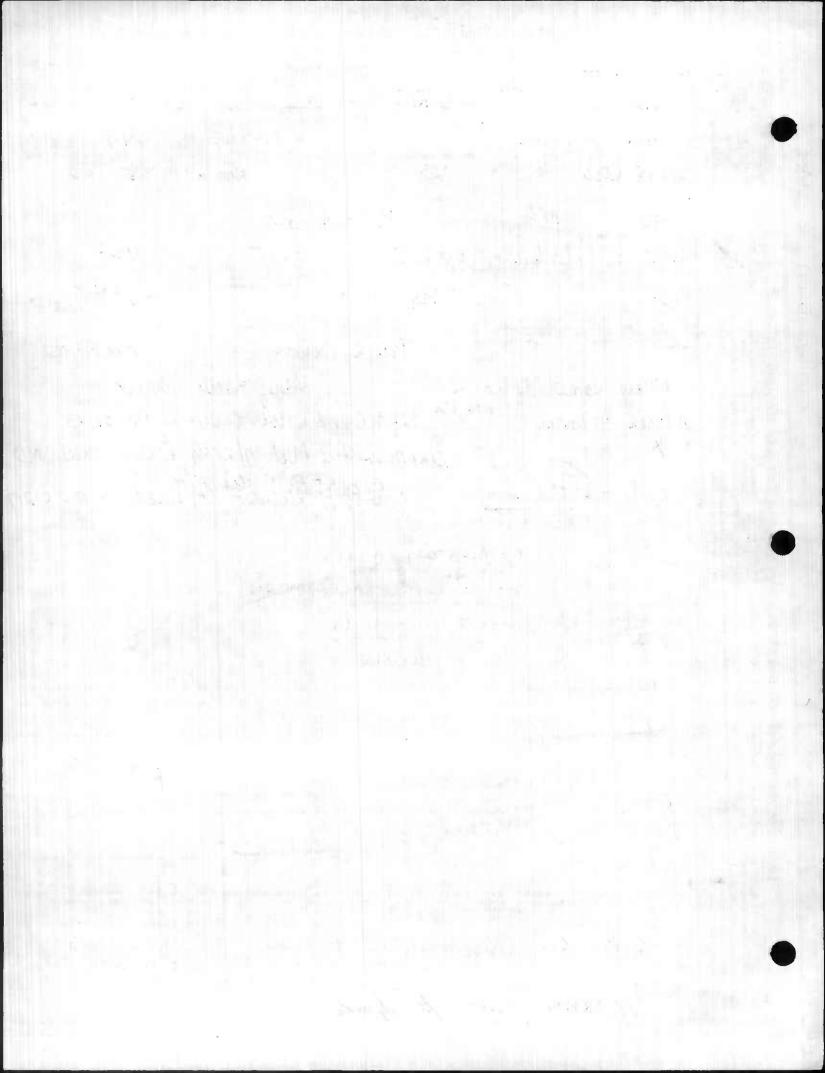
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State Registrar

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JUL 28 1999

82. Registrer's Signetury. Sparks



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. 99-4352-005 State of Maryland / Department of Health and Mental Hygiene 9
GEORGE JAMES AMEND ITEMS: 23 PART I, 27, 28A-F PER MEO G77 Certificate of Death

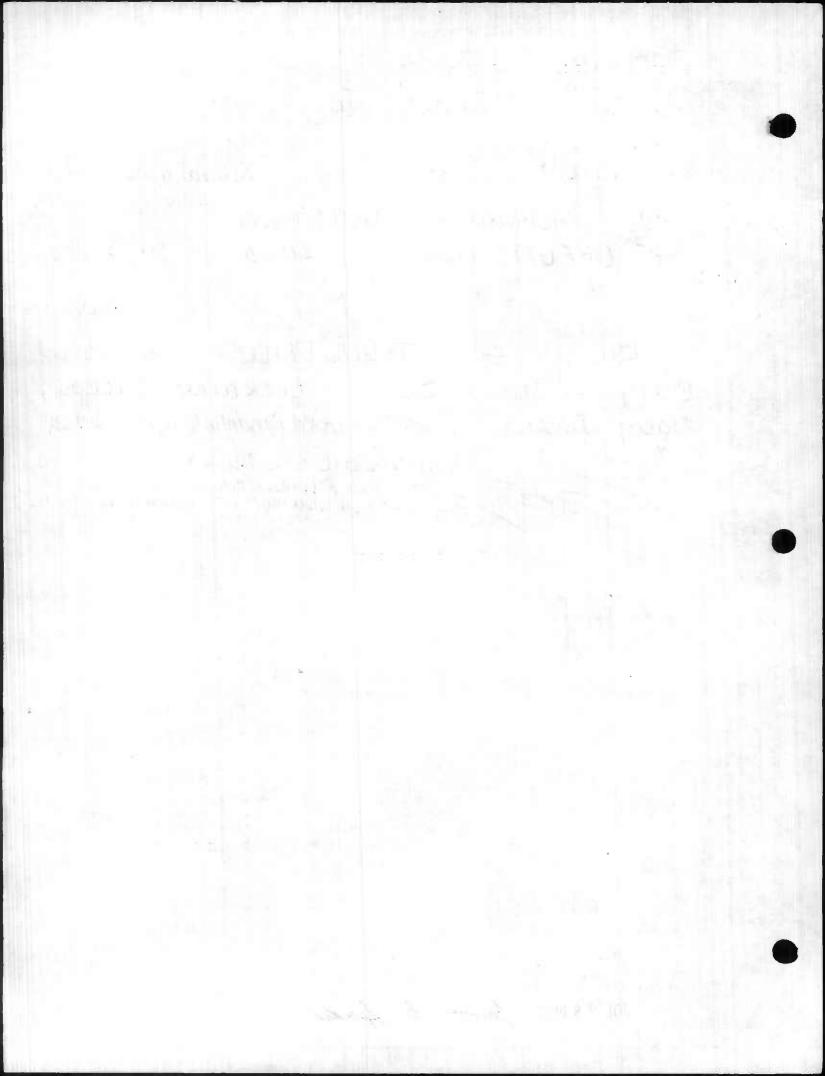
Reg. No. 1. Decedeni's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 23, 1999 Year Month **Physician** 7.05P.M. a /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If no institution, give street and number) 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 6. Sex 10 M 2□ F If Under 1 Year 5. Social Security Number 7. Age (In yrs last birthday) 9. Birthplace (Stete ox Foreign Country) Funeral Hours 216-18-6272 Usuai Residence of Decedent Months Days Director the Maryland 10a, State 10b. Coun 10d. Inside City Limits 28a-f show 1 Yas 2 No Director 10g. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? ò Items 23s Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Merital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or itse 1 Never Married 210 Merried 1 Yes 2 Il Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: py 3 ☐ Widowed 4 ☐ Divorced meric Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) Be Peges 1 and 2 should be ne 01 19a. Informant' ame/Relationship (Type, Print) Sportee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Heelth ar Important: If Item 27 is any injury or other trau-once. vaalu 20a. Method of Disposition
1 Webrial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ricenses Gulmor 38 LHIMORE, MO21217 6 the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Fina ACUTE COCAINE INTOXICATION disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in deeth) Last and Due to (or as a consequence of) physician a Box 68760. Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 3 Probably 4 Unknown 1 Yes 2 No ò 24b. Wara autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 10 Yes 1 TYes 2 No 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient edical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours efter death.

• Funeral Director: Aft

pletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 7-23-99 UNKNOWN SUBJECT TOOK DRUG 2 Accident 6 Could not be determined 3 X Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide UNKNOWN Hospital UNKNOWN 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and tiffle of certified 29c. License number 29d. Dete aigned (Month, Day, Year) 0 JULY 24, 1999 D.C.M.E. pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co W 111 Penn Street, Baltimore, Maryland 21201 L 28 32. Registrer's Signeture State 1999 Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** KEPPER CATHERINE 3:50 PM 24 JULY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL -GENTGR N/A 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthpiace (State or Foreign Country) **Funeral** Months Days 1XIM 2□ F 215-01-0918 Yrs. 85 Director Maryland Usual Residence of Decedent Demit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental hygiena. Important: if item 27 is merked other than "natural", or items 23a or 28a-f ahow any lojury or other traumatic avant, the Modes Experience. 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1DXYes 2 No Baltimore Maryland N/A Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 704 Harvey Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian. 11. Maritai Status Biack, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Factory Worker Distillery 0 6 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Agnes George Huber Lamarr 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) 704 Harvey St., Baltimore, Maryland Raymond G. Kepper (Son) 20b. Piace of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBuriai 2 Cremation 3 DRemoval from State Glen Haven Memorial Pk. 7/28/99 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21 Sonature of Funeral Prvice Licensee Kevin E. Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Baltimore, Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Betwe Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical SEPTICEMIA 2 YAG **Examiner** Examiner ISCHEMIC BOWEL PERFORATION WEGK physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): REPIRATORY WEEK Division of Vital Records, P.O. Box 68760, FAILURG Physician/Medical Due to (or as a consequence of): 88 080 Por signed by the a d be detached f 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 1 Yes 2 Np 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? been signated 24a. Was an autopsy performed? Completed s certificate has b director, page 2 s or Attanding Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Deeth Check only one 1□ Yes 20 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 28b. Time of After Natural
Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier 🖈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the ceuse(s) end manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated. (Check only one) \$ 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartified 29c. License number RESIDENT 12797. JULY 24 1999 SCUTH HANDVER STREET 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 3001 SHWE MRA GHAW BALTIMORE

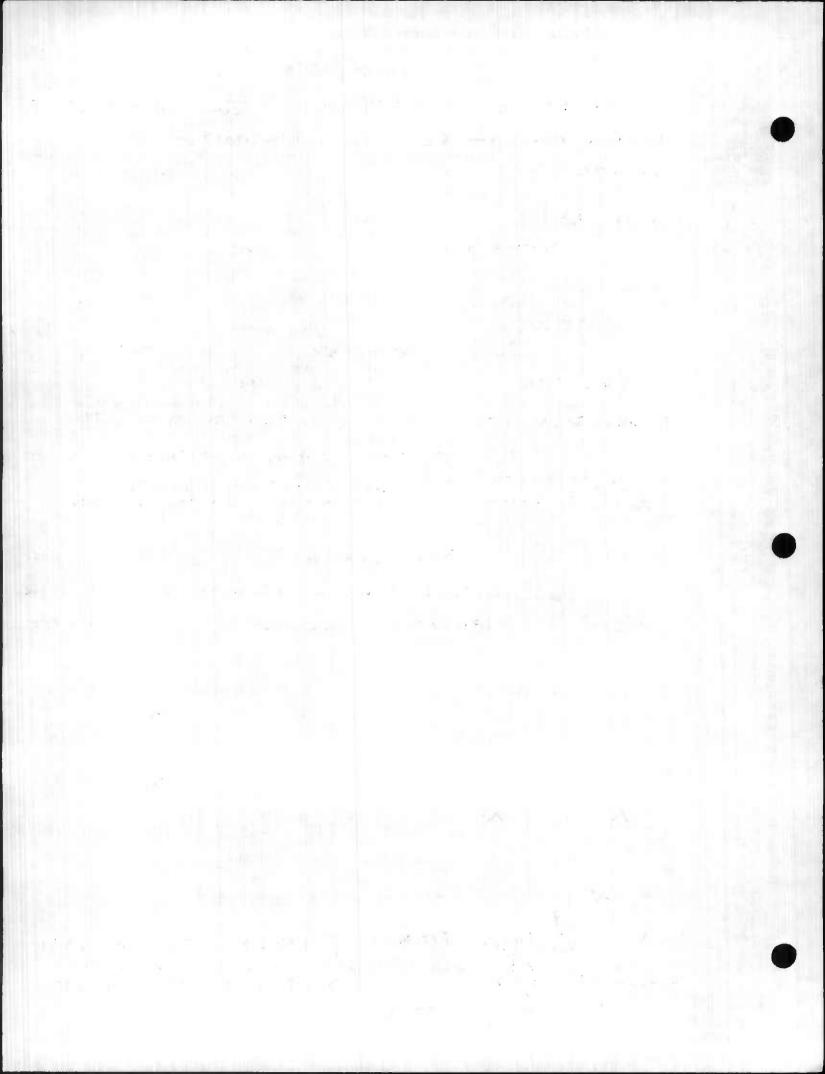
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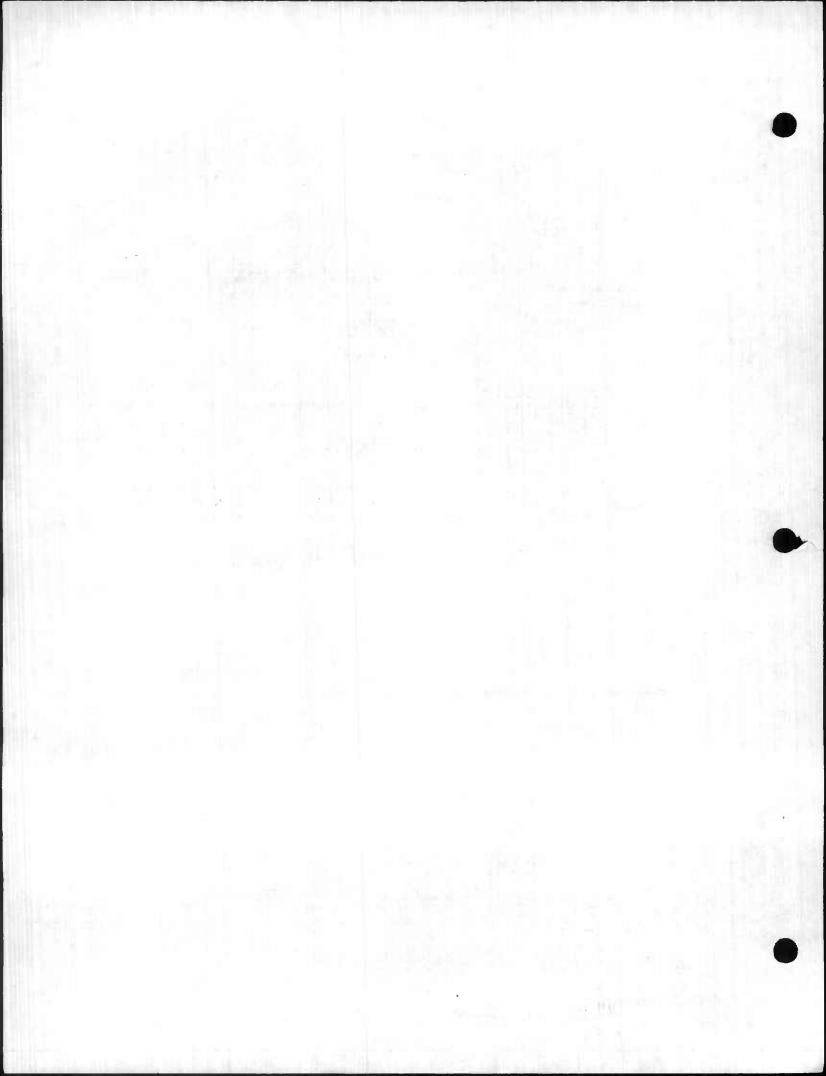
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32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Decedent's Name (First, Middle, La	ist)	Cel	rtificate of	Dealli	2. Date of Dea		3. Time of Deat	h		
Physician /Medical		argaret Mario	n Linds			July 2	-	9:03 P.M	1.		
kaminer	4e Facility Name (If not Institution, give	The Latest Committee of the Committee of			4b. City, Town, or		,	Arundel Co.			
eral ctor	Anne Arundel Med 5. Social Security Number 6. S 266–38–2291		yrs. last birthday) Yrs.	If Under 1 Year Months Days	Annapol If Under 24 Hrs. Hours Min.		r, Year)	9. Birthplace (State or Fon Country) Florida	eign		
	Usuel Rasidence of Decedant 10a. Stata 10b. County	100	. City, Town or Lo	cation				10d. Inside City Lim	ite		
to		rundel Co.		Pasadena	1		1 ☐ Yas 2√€ No				
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?			
<u>a</u>	8381 Sail Circ	le		211	22		U.S.	A.			
Operations of the state of the	11, Meritel Stetus 1 ☑ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forcas? 1 Yas 2 No If Yes, Giva Yaar or Datas:	·	Was Decedent of If Yas, specify Cub	tispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yas or No- o Rican, etc.)		e - American Indian, k, White, atc. White			
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15a. Decedent's Usual Occupation (Give kind of work done during most of we lifta. DO NOT use retired) Teacher 16a. Decedent's Usual Occupation (Give kind of work done during most of we lifta. DO NOT use retired) Teacher						Board	ofEducation Arundel Co.			
9	17. Fathar's Nema (First, Middla, Last					ne (First, Middle,	Maiden Sumam	e)			
To	19a. Informant's Neme/Ralationship (19b. Mailir	ng Address (Street	and Number or Ru			Stata, Zip Code)			
	Dorcas Hayes	Friend			ccle Pasa	dena,Mar	yland 2	1122			
	20e. Mathod of Disposition 1 □ Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specification of the control	Ramoval from State (b. Place of Dispo cematery cree GreenMoul	sition (Nama of majory or other pla NE Cremat	fory	7/28/9	Paltim	City or Town, State pore, Maryland			
Buce	21. Signature of Funeral Service Licer	Collins	Me	204 Mount	olyniak F tain Road	Pasader	a, Maryl	and 21122			
	23a. Part1 Intar tha diseasa, or com shoot, or haert failura. List only	plications that caused tha cona causa on each line.	leeth. Do not ent	ar tha mode of dyi	ng, such es cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Deeth			
n il er	Immediate Causa (Final diseesa or condition a Metastatic Cancer to liver (mother assulting in death)										
ner		, endom	o (or as a consec	Can C	11			9 month	25		
Examiner	Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or Injury	4.	o (or as a conseq								
//Medical	Cause (Disease of Injury that Initiated avents resulting In death) Last	d	o (or as a conseq	uence of):				E = 187			
Iclar	Part II. Other significant conditions of	ontributing to death but not	ven in Part I	23h Did t	obacco usa cor	ntribute to the cause of de	nth?				
by Physician/M	Total agricultural conditions	On Doing to Coath out not	resounty of the or		TOTAL TOTAL	101	d	3 Probably 4 Unkr			
Completed b						24a. Was a performance		24b. Were autopsy finding available prior to completion of cause of death?	gs		
Com						1 D Y	es al No	1 ☐ Yes 25 No			
a	25. Was case referred to medical examiner?	Hospital: 🔽		011		ath (Check only o	ne)				
٦.	1 Yes 2 No	Hospital: 10 Inpatient :	2 ER/Outpatien	I 3LI DOA		ioma 5 ☐ Resid					
Certification:	1 Natural 5 Pending 2 Accident invastigation 3 Suicide 6 Could not b	(Month, Day Yea	r) Injury	M 1				er or Rural Routa Number,			
	4 Homicide datamined	28e. Place of Injury - / building, etc. (Sp	ecify)		me date and al	City or Tow	n, Stata)				
edical	(Check only one)	yalcian: To the best of my niner: On the basis of axan end mannar statad.	nination and/or inv	restigation, in my o	opinion, death occu	r, and due to the d irred at the time, o	data and place,	and due to the cause(s)			
ž	29b. Signatura and titla of certifier			29c. Licens	se number			d (Month, Day, Year)			
	V	verre, m	_		2830		244	25,1999			
	30. Name and addrass of person who Teanine we				20ad	trnaps	dis, mi	9 21401			
State	31. Deta filed (Month, Day, Year)	32. Registrar's S		1							

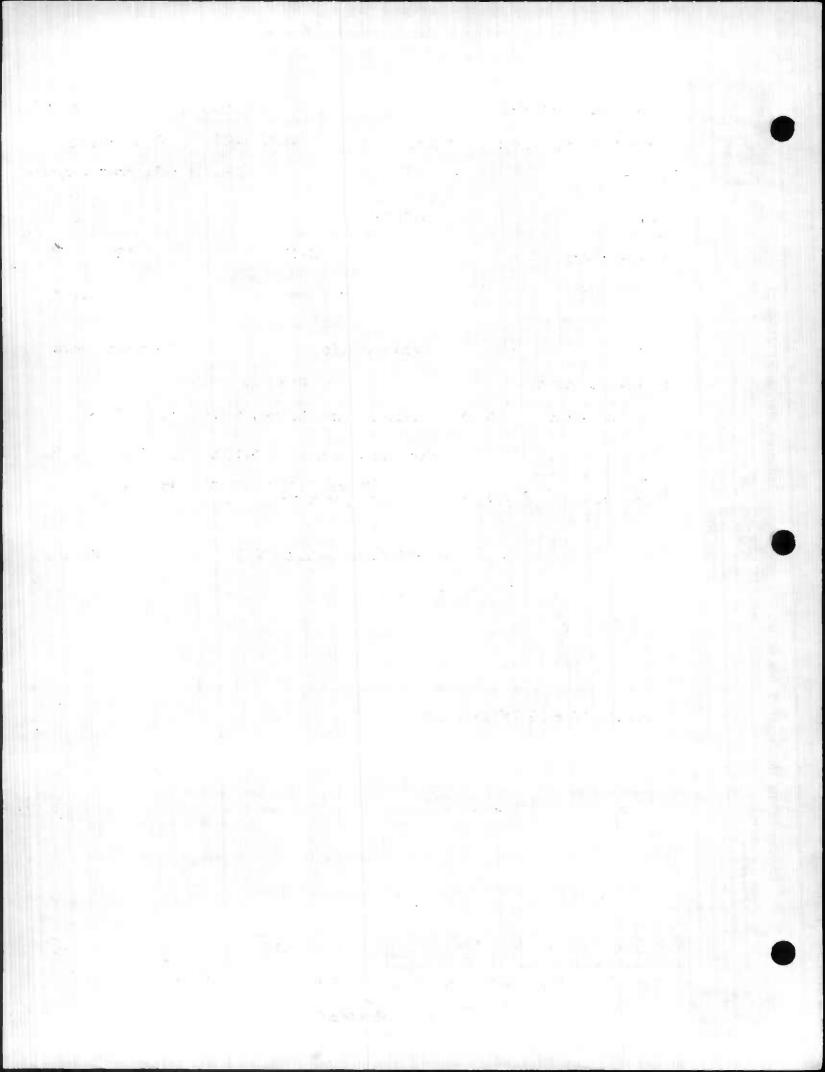


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State of Maryland /	Department of Health	and Mental Hygiene	C
	•		100.00

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** 1:45 AM ISAAC LESTER JULY 1999 /Medical 4e Fecility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE CENTER HARBOR HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 10M 20F Months 73 West Virginia Director June 21 1926 236-32-0132 Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

7 Is marked other than "natural", or frems 23a or 28a-f show traumstic event, the Medical Examiner must be notified as 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore 1√2 Yes 2 No Md. n/a Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1421 S. Carey Street 21230 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify: white Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 16b. Kind of Business/Induatry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Oldsmobile Dealer Auto Mechanic 5 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filt thent of Health and Mental Heart: If item 27 is marked oth jury or other traumatic even Be Cosby C. Stanley William O. Lester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informent's Neme/Reletionship (Type, Print) 1421 S. Carey Street, Baltimore, Md. 21230 (Wife) Evelyn A. Lester 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 Suriel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 7/29/99 Brooklyn Park, Md. Cedar Hill Cemetery 22. Name and Address of Fecility 21. Signeture of Funeral Service Licensee McCully-Polyniak Funeral Home P.A. 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart tellure. List only one ceuse on each line. **Physician** /Medical Immediate Ceuse (Finel . CEREBRAL VASCULAR ACCIDENT disease or condition resulting in death) Examiner Due to (or as a consequence ot): Examiner HYPERTENSION The law requires that the death certificate be asscuted physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): attending pl signed by the a d be detached f Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4₺Unknown 1 ☐ Yee 2 ☐ No CORONARY ARTERY DISEASE g 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? s certificate has t director, page 2 s 1 ☐ Yea 2 XNo 1 Tyes 2 No or Attending Physician: funeral director, Be 25. Was case reterred to medicel 26. Place of Death (Check only one) Hospital: 1 Malinpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident after deat Director: 6 Could not be determined n 24 hours after dec to Funeral Director pletely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certified MD. P12136 (-2, as 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) S. HANOVER ST. BALTIMORE MD Q1223 -OXLEY, TANG QING 3001 32 Registrer's Signature 31. Dete filed (Month, Day, Year) State JUL 28 1999 Registrar



Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

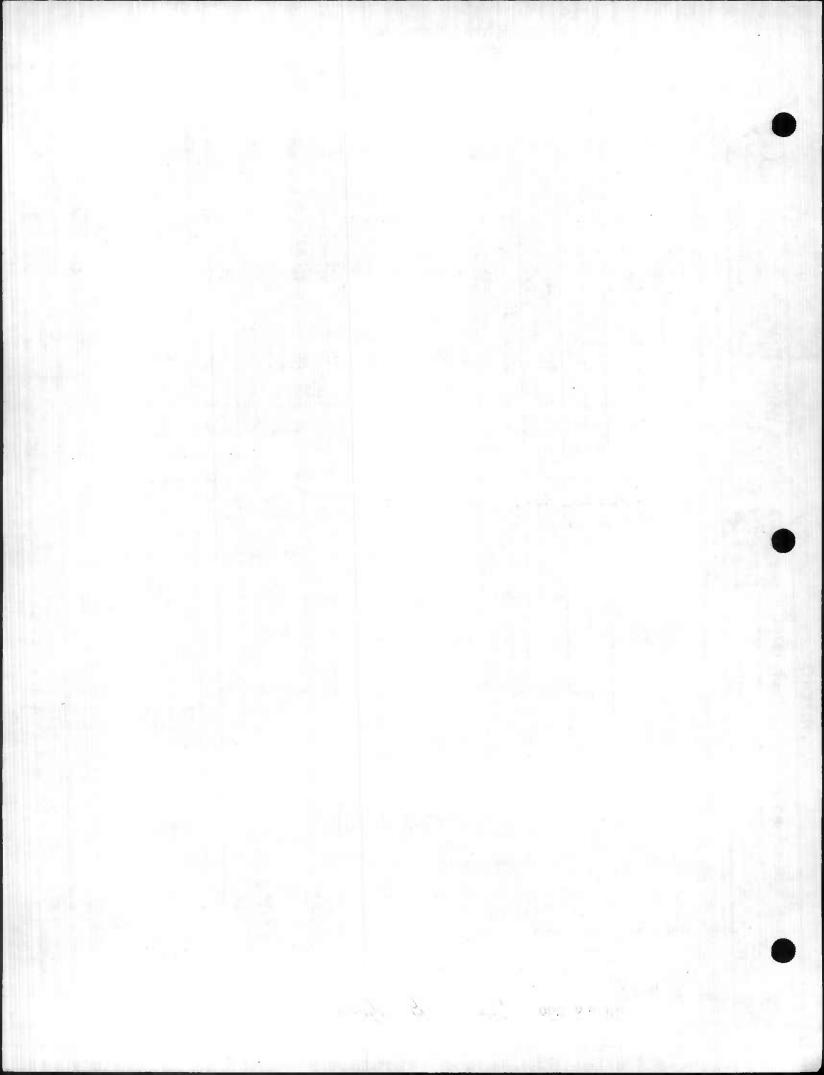
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1. Decedent's Name (First, Middle, I		06	Timeate C	f Death		leg. No.			
Cooccin a Hanno (First, micelle, t	Last)				2. Date of Dea Month	th Day	Year 3. Time of		
	er Lance			41 Oh T		8, 1999			
4a Facility Neme (If not institution, g	223-277			4b. City, Fown, o	or Location of Death	4c. County	of Death		
3 West Preston S 5. Social Security Number 6		rs. lest birthday	If Under 1 Ye	Baltin	Ore rs. 8. Date of Birth	N/			
The state of the s	M 2□ F	Vre	Months Da		n. (Month, Day	, Year)	9. Birthplace (State of Country)		
212-46-8042 Usuel Residence of Decedent		50			10ct. 24	1948	Maryland		
10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside Ci		
MD N/A		В	Baltimor	е			POX/es		
10e. Street and Number			10f. Zip Cod			log. Citizen of \			
4124 Potter Stre	eet, Apt. 302		212	29		US	SA		
11. Maritel Status	12. Was Decedent Ever in Armed Forces?	U,S. 13.	Was Decedent	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ce - American Indian, ck, White, etc.		
Never Married 2□ Merried	1 Yes 2 No		1□Yes 2⊡				Black		
3 Widowed 4 Divorced	Year or Dates:								
15. Decedent's (Specify only highest of		(Give	dent's Usuel Oc a kind of work do DO NOT use re	ne durina most of w	orking	160. Kind of B	usiness/Industry		
Elementary/Secondary (0-12)	College (1-4or 5+)	m0.							
17. Father's Neme (First, Middle, La.	st)		Custo		Newst Maiden Suman	spaper			
Saulters Lance									
Saulters Lance Daisy B. Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or To									
Glorius Smith/Sis	Balto.	, MD 21229							
20a. Method of Disposition		. Place of Dispo	osition (Name of matory or other		Date		ion - City or Town, Stete		
1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ing Mem	orial P	ark	¢7-24-99	Randall	lstown, MD		
21. Signature of Funeral Service Lic	ensee	2	2. Name and Ad	dress of Facility	aple Fune	ral Ser	rvice		
10.(20 2						aryland 212		
23a. Part Enter the disease, or respect or head failure. Lies on	mplications that caused the de						Approximat Interval Bet		
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.									
Immediate Cause (Finel disease or condition	Hypertensiv	Hypertensive Arteriosclerotic Cardiovascular Dise							
resulting in death)		(or as a conse					ase		
			querice or).			- 11	ase		
	b		querica orj.			48	ise		
Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse				- 13	ise		
if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C		quence of):				ise		
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State Registrar

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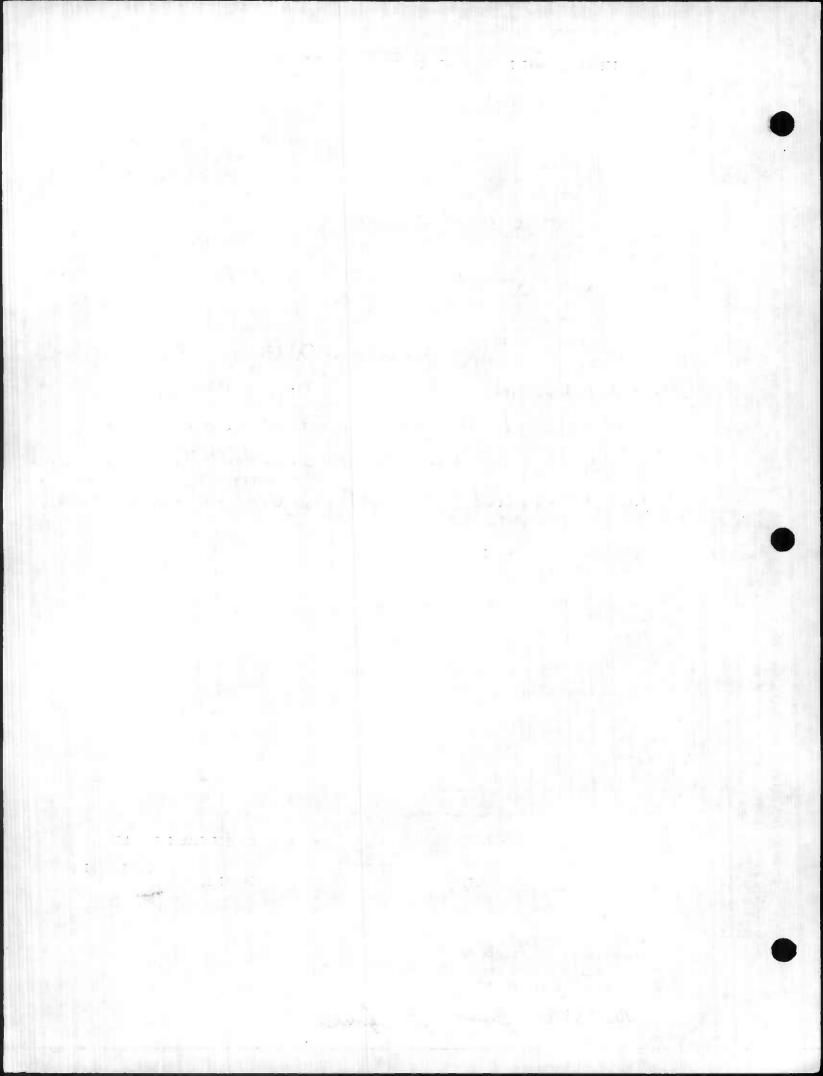
^{23a)} (Type, Print) 709 E. Lombard St., Baltimore, Maryland 21201



erry P. Lipso	comb AMEND ITEMS: #23 P	State of Marylar ART I, 27, 28A-F	nd / Departme	nt ₈ of Health _R and	d Mental H	/giene 9 9	23	718		
Physician /Medical	1. Decedent's Nama (First, Middle, Last) Jerry Paul Li	pscomb, St.			2. Data of D Month July or Location of Des	Day 26, 19	Year 0	ima of Death		
Funeral Director	4e Facility Nemē (If not institution, give s Dorchester General 5. Social Security Number 9.25-17-4121		A A math	Cambri	idge	Doro	9. Birthplace (S	State or Foreign		
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os 1 and 1 tem 2 t	Carolyn M. Lipson 20a. Method of Disposition 1 X Buriat 2 Cremation 3 CR 4 Donation 5 Other (Specify)	nb lwite	104 Riplace of Disposition (Nemptery, crematory of Air Men	Lac Ave. La	ansdowne 129199	md21	227 City or Town, St			
Baltimo	21. Signature of Funeral Service Licentee	mboll	2719	and Addrass of Facility Hammonds	mbrose i Ferry Rd	Funeral 4 Lansdoc		Lanslaux 21327		
Physician /Medical Examiner	23a. Pert1. Entar tha disaasa, or complishook, or heart failure. List only on Immediate Cause (Finel disaase or condition rasulting in death)	DROWNING	or as a consequence o				Interv	al Between t and Death		
68760, ifficete be assected gphysician and as the burial-transit ledical Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last		or as a consequence of				8 5 8 8			
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f Vital Record yalcien: The law require is certificate has been si director, page 2 should To Be Completed	25. Was casa ralarred to medical			26 Plane of	Death (Check only	Evos 2□No	1 Zyes	2 No		
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Division of To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	3 Sulcide 6 Could not be detarmined	28a. Place of Injury - Al hi building, atc. (Specif WATER	oma, farm, street, fact y)	ory, office	281. Location City or T CAMBRIDE	(Street and Numbown, State) CH(op fank" Riv	e Number, E R		
the Hosp hin 24 hos the Fune npletely fi	(Check only one) XZX Medical Examin	Ician: To the best of my kno er: On the basis of examina end mannar stated.	tion and/or Investigation	on, in my opinion, death o		, data and place,	and due to the c			
To the within To the Common	29b. Signature and Itila of certifier 30. Name and address of person who cor	Chute no		9c. License number O.C.M.E.			d (Month, Day,)			
State Registrar	Dennis J. Ch 31. Date filed (Morth, Day, Year) JUL 2 8 1999	7 ute NO 32. Registrar's Signa	111 Per	n Street, B	altimore	, Marylan	nd 21201	(leappe) Tou		

DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician SHERRY LANE 24 1999 LUCAS July 11:45 am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not inatitution, give street and number) 4c. County of Death Examiner Univ. of Maryland Medical System Baltimore If Under 24 Hrs. 8. D If Under 1 Year 8. Date of Birth (Month, Day, Year) Aug. 26, 1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 10 M 20 F Days Min. 51 North Carolina 217-50-0575 Director Usual Residence of Decedent the Maryland 10a State 10b Counts 10c. City, Town or Location 10d Inside City Limits ahow r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Md. Baltimore Owings Mills 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 St. Thomas Lane 21117 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detea: Black, White, etc. 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i filed within 7 i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Travel Agency 12 Administrative Assistant permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If Item 27 is marked other 1 any Injury or other traumatic event. In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Hal Baker Lucas Bessie Jane Baldwin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4810 Stafford St., Baltimore, Md. 21229 Brenda K. Lucas - Cousin 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Lake View Mem. Park July 28, 1999 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility 21117 Eckhardt Funeral Chapel ran 11605 Reisterstown Rd., Owings Mills, Md. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, set failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Necrotizing Soft Tissue Infection 6 weeks Examiner Due to (or as a consequence of): Examiner Sensis 24 Hours siclan and burial-transit Sequentially its, conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). ding physician Physician/Medical Due to (or as a consequence of): 88 Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by 1 Yes 2 No 3 Probably 4 Unknown insulin dependent diabetes mellitus Records, þ B 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Deen end stage renal disease has 1 Yes 2 No calciphylaxis 1 Yes 2 No certificate 25. Was case referred to medicat examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Attending 1 Natural
2 Accident 5 Pending investigation or Attending after death. Director: Aft 1 Yes 2 No 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital
 24 hours a
 Funeral C 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD43055 27 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Pay, Year) 1999

NADER

HABASHI 32. Registrar's Signature

22 South Greene St. Baltimore, MD

of Vital

Division

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mentai Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SALVATORE MICCICHE 26 July 1999 04:51 A.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel General Hospital Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Oct. 24, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 219 16 0394 74 Maryland 1924 Director Usual Residence of Deceden the Mandend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or flams 23s or 28s-f show treumstic event, the Medical Examinar must be notified at MD Queen Anne 1 ☐ Yes 2 No Stevensville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 LaGorce Dr. 21666 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiens. Important: if frem 27 is marked other than "natural, or frem eny injury or other treumatic event, the Medical Exercised and an additional pages. Black, White, etc. 1 Yes 2 No if Yes, Give Year or Detes: Baitimore, Maryland 21215-0020 1 Yes 2 X No Specify: þ 3 Widowed 4 Divorced WW II white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self employed Trucking 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Frank Micciche Thelma Baines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willa D. Micciche 216 LaGorce Dr. Stevensville, MD. 21666 (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/29/99 Meadowridge Mem. Park Elkridge, MD 21075 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ 21. Signature of Funeral Service Licenses Meadowridge Mem. Pk.,7250 Wash. Blvd.,Elkridge,MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypoxic **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) BRan Seconds Examiner Due to (or as a consequence of) ordiac asre that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Last Bud Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the. Due to (or as a consequence of): Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by t 2 No 3 Probably 4 Unknown Division of Vital Records. P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No certificata Hospital or Attanding Physician: 24 hours after death. 25. Wes case referred to medical examiner?

1 Yes 2 Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Spatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 3 Suicide 6 Coutd not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homlcide To the Hospital or within 24 hours after To the Funeral Directors of th 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ststed.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier/ 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Franklin St., Annapolis, Md. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

DHMH 16 Rav 6/95

Registrar

2 8 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Death Julia Month MARTIN 4e, Eacliity Nama (If not institution, giva street and number) b. City, Town, or Location of Deeth glan Dato Cent nsg If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 1□M 2XF Days 195-12-361 04 18 1922 Virginia Usuel Rasidance of Dacedant t0a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2 No Md. M/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1729 Ruxton Avenue 21216 U.S.A.

14. Race - American Indian,
Black, Whita, atc. 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes = 2X No If Yes, Giva Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 11. Maritel Stetus 1 Navar Marriad 2 Marriad Specify: Black 1 ☐ Yas 2 ▼ No Specify: 3 DWidowed 4 □ Divorced 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collage (1-4or 5+) Housewife Private 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Neme (First, Middla, Maidan Sumama) Junis Richardson Lena Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Yvette Clay/Niece 604 Yale Avenue, Baltimore, Maryland 21229 20e. Mathod of Disposition 20b. Plece of Disposition (Name of cematary, cramatory or other piece) 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Steta 4 ☐ Donation 5 ☐ Othar (Specify) Eden Cemetery 7/30/99 Collington, PA. 22. Nama end Address of Facility William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Mo. 1217

23a. Part1 Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest,

Approxime Approximate Interval Batween Onset and Deeth Hear Immediata Causa (Final Decompensated disaase or condition rasulting in daeth) Atherosclerohe Sequantially list conditions, if any, leading to immediata cause. Entar Undarfying Causa Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Ware sutopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yas 2/2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Othar: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Panding investigation 1 Yas 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

by

Completed

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Madical Examiner framt on notified at

permit. Pages 1 and 2 should be filed within 72 hours afti. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or i any injury or other traumatic event, are Medical Example 2008.

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital or Attending Physician:

The lew requires that the death certificate

certificate

After this

death.

after death Director:

within 24 hours a To the Funeral C Hospital

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Medical

the Maryland

Examiner Physician/Medical þ Be Completed

physician and the burial-transit signed b cate has been sig , page 2 should b filled in by the funeral director, 2 Certification:

25. Wes casa rafarred to medical

1 Yas 2 No 27. Mannar of Death Natural

29a Certifier

(Check only one)

2 Accident 3 Sulcide 6 Could not be 4 I Homicida

28e. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29b. Signeture end title of certifie

asanthalcum.

29c. Licanse number D42170 29d. Data algned (Month, Dey, Year)

30. Name and edd/ass of person who completed cause of death (Item 23a) (Type, Print)

ASAWTHA CUMAN MD 821-N EUTHUST SUITE 407 MDZ1201

State Registrar

32. Ragistrar's Signatura

mentals to the second

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** MCCOY EUNICE 1999 JULY 26 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTI FARKU CARE CENTER MORE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 1□M 2⊠F 402-14-6652 80 Dec. Director Usual Residence of Decedent the Meryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow tem 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified as 1 Yes 2 No Director Jefferson Ky. Fairdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40118 USA 10107 Keys Ferry Rd. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baitimore, Maryland 21215-0020 à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental hygiene. Important: If hem 27 is marked other than "seny injury or other treumatic event, the Heal Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) 8 Booth Crabb, Sr. Lawrence Eunice McCov 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carol Ann Frost/daughter 1301 McPherson Ct. Lutherville, Md. 21093 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 DOther (SpecifyEntombment Evergreen Cemetery 8/2/99 Louisville, Ky. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tellura. List only one cause on each line. Approximate Intervel Between Onset and Daeth **Physician** /Medical Immediete Cause (Finet disease or condition resulting in death) Cerebrovascular Examiner Examiner herosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): physician of the burlair Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably € Unknown 1 ☐ Yes 2 ☐ No Bleeds, Coronary Artery 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medicat axaminer? Be 26. Place of Daath (Check only one) axaminer?

1 Yes 2 No

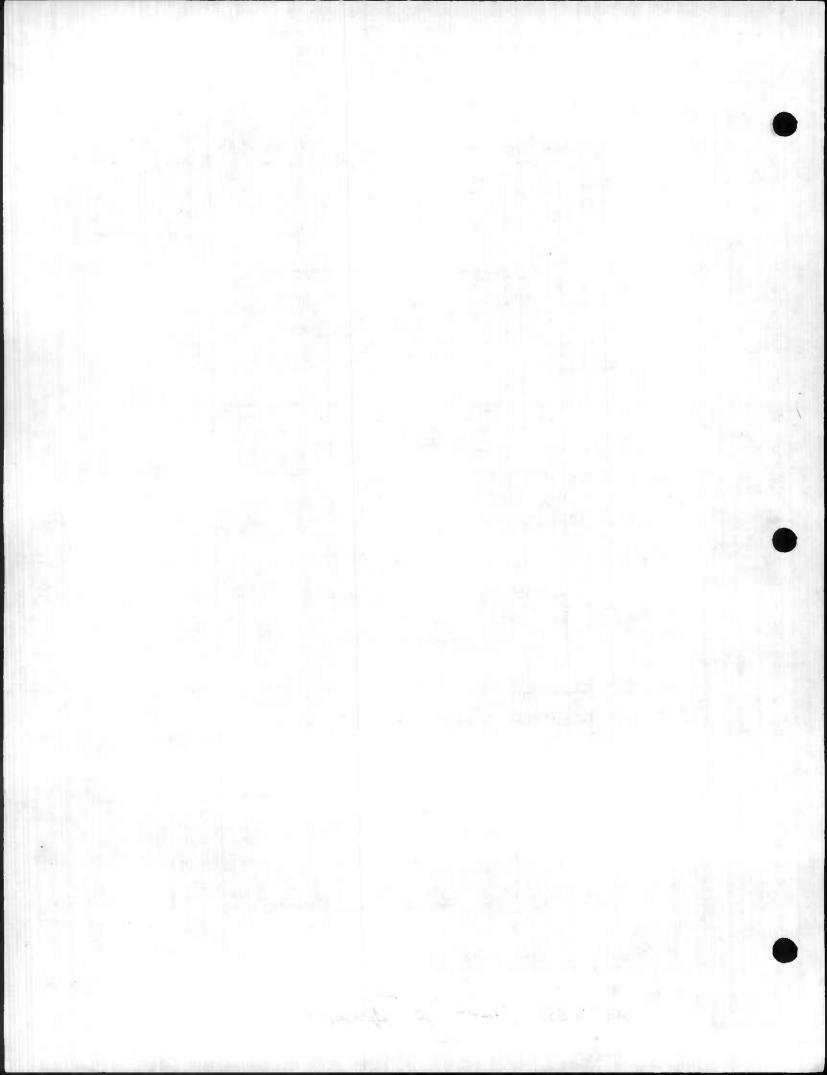
27. Manner of Death

1 Natural 5

2 Accident Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkville, Md L 2 8 1999 Registrar's Signature State Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month 26 1999 Adam Paul Melocik July 12:30PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months Days 1⊊M 2□ F Yrs 95 Director 705-09-0506 Jan. 27 1904 Maryland Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits iner over be notified at Director N/A Baltimore City 1⊠Yes 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 1531 Woodbourne Ave. 21239 USA Funeral items 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 natural', or 1 ☐ Yes 2 ☑ No by Specify: 3 Widowed 4 ☐ Divorced White traumatic event, the Medical 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry marked other than Elementery/Secondary (0-12) College (1-4or 5+) 12 Rate Clerk B&O Railroad Deperment of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traument— 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Adam A. Melocik Marv Soul 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Robert P. Melocik/Son 8302 Alston Rd. Baltimore, MD. 21204 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete Buriel 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Most Holy Redeemer Cemetery 7-31-99 Baltimore, MD. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23e. Pert1. Enter the diseese, or shock, or heert failure. List cations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Interval Between Onset and Death Physician Immediete Ceuse (Finel Adenocarcinoma disease or condition resulting in death) Examiner Drimany site months Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Physician/Medical Due to (or as e consequence of) Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b þ pege 2 should Be Completed 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes an eutopsy performed? 1 Yes 1 Yes 2 No Division of Vital Physician: 25. Was case referred to medical 26. Place of Death | Check only one Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 X her (Specify) To Spice 2 1 Yes 2 No this 28e. Date of injury (Month, Dey Year) 27. Menner of Death edical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After or Attanding 5 Pending Investigation 1 Neturel 1 Yes 2 No death. 2 Accident after death in by the 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ HomicIde To the Hospital of within 24 hours at To the Funeral D completely filled i To Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted. 29a, Certifier 29b. Signeture and title of cartific 29c. License number 29d. Dete signed (Month, Day, Year) 025205 wo 30. Name and eddress of person who completed cause of deeth (Item 234) (Type, Print) N. Charles St. Balto, md 21236 .A.Rile. (GBMC 6701 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State JUL 28 1999 Registrar

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death Day Month Year 1999 JU

3. Tima of Death

7:25PM

10d. Inside City Limits

29d. Date signed (Month, Day, Year)

1 ☐ Yas 2 ☑ No

1. Decedent's Nama (First, Middla, Last) **Physician** Louise Manetta /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, give street and number) Examiner Rose dale If Under 24 Hrs. 8. Da Cente Baltimore Franklin Hospital Square 6. Sa If Undar 1 Yaar 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 5. Social Security Number 6. Sax **Funeral** Months Days 1 M 2 F Hours 177-52-6565 Director April 20, 1922 Wyoming Usuai Rasidance of Decedan death with the Maryland 10c. City. Town or Location show 10a. Stata 10b. County 7 is marked other than "natural", or Nems 23s or 28s-f show traumatic event, the Modical Examinar must be notified at Director Columbia Berwick 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1803 North Vine St. 18603 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural". ~ in DBG. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 11. Maritai Status Biack, Whita, atc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No Specify: Specify.white 2 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life, DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) lanetta, Louise Elementary/Secondary (0-12) Coilega (1-4or 5+) unknown unknown 18. Mothar's Name (First, Middla, Maiden Surname) 17 Fathar's Nama (First Middla Last) Natale Marconi Marie Fratesi 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Daniel V. Manetta/son 1803 North Vine St., Berwick, PA 20b. Piace of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☑ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Service Licensee 22. Nama and Addrass of Facility Joseph B State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Inter the disea of complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physiclan** /Medical Immediata Causa (Final Anoxic Encephalopathy disaasa or condition resulting in death) Examiner Electrica Examiner GP LSS certificate be executed physician and the bunal-tran Sequentially list conditions, if any, laading to immadiata ceusa. Enter Underlying Cause (Disaasa or injury that initiatad events resulting In death) Last Bladder Invasion Colorecta Cancer with Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consaquance of): 80 980 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. signed by t 1 Yes 2 No ò 24a. Was an autopsy Completed

loper

32. Registrar's Signatura

30. Nama and adv ass of person who complated causa of death (item 23a) (Type, Print)

page 2

has certificate funeral director, Be 2 Certification:

or Attending Physician: this After efter death. Director: Aft 24 hours e

Hospital

To the I within 2

State Registrar

Medical

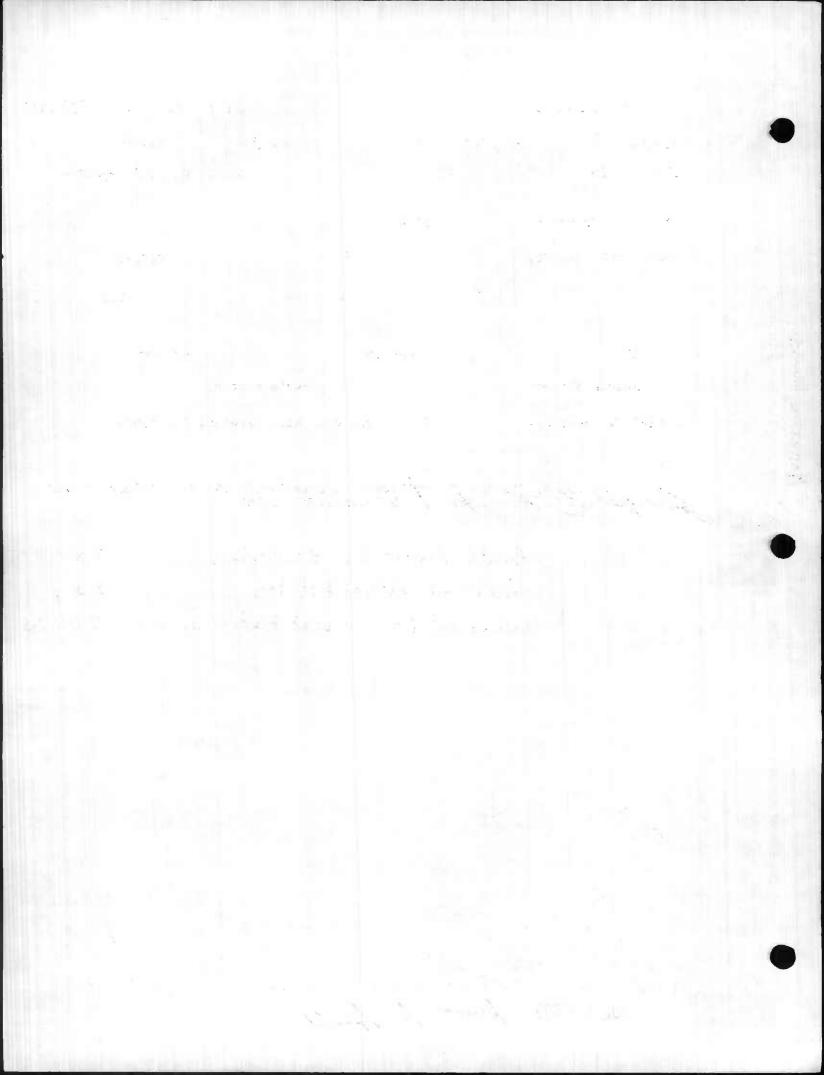
29b. Signature and title of certifier

Dr. Luis Lopez 31. Data filed (Month, Day, Hear) JUL 2 8 1999

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? t Ven ZNNo 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Rasidence 8 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of Injury 5 Panding 1 Yes 2 No Invastigation 2 Accident 6 Could not be datamined Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and partner stated. 29a. Certifier (Check only one)

29c. License number

9000 Franklin Square Drive Battimore, Maryland



hysician	Decedent's Name (First, Middle, La George Lelas	nd Meinschei			icate of			2. Date of De Month JUNE	Reg. No.	199	Year	3. Tima of Death
/Medical xaminer	4a Facility Name (If not institution, give 63 AMBO CIRCLE		11			4b. City, To BALT:		cation of Death	h 4c. (County o	-	1625 PM
ma 23a or 28a-f ahow ma 23a or 28a-f ahow marai Director	5. Social Security Number 6. S unknown Usual Residence of Decedent	®M 2□F	0.00									ce (State or Foreign v) n
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Mental Hygiene arter of the arter of the arter overt, the Hedgel Earning TO Be Completed by Fu	11. Marital Status unknown 1 ☐ Never Married 2 ☐ Merried	12. Wes Decedent Ever Armed Forces? un 1 Yes 2 No If Yes, Give Year or Detes:	n u.s. known					ecify Yes or No Rican, etc.)	- 1	14. Race Black	- American K, White, et whit	c.
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ician dical niner	23a. Pert1. The the disease, or comshock, or heer feilure. List only Immediate Cause (Final disease or condition resulting in death)	. Ate	deeth. Do n	ester the	fiz (MD ing, such as	2120 cardiac o)1	irrest,		ease	Opproximate Interval Between Onsel and Deeth
Examiner Examiner	Immediate Cause (Final disease or condition	a. Due	io Se	consequence	e mode of dy	MD ing, such as	2120 cardiac o) 1 or respiretory a	irrest,		lase	Approximate nterval Between
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Registrar

JUL 2 8 1999

State gistrar

JUL 2 8 1999

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signeture

JUL 2 8 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

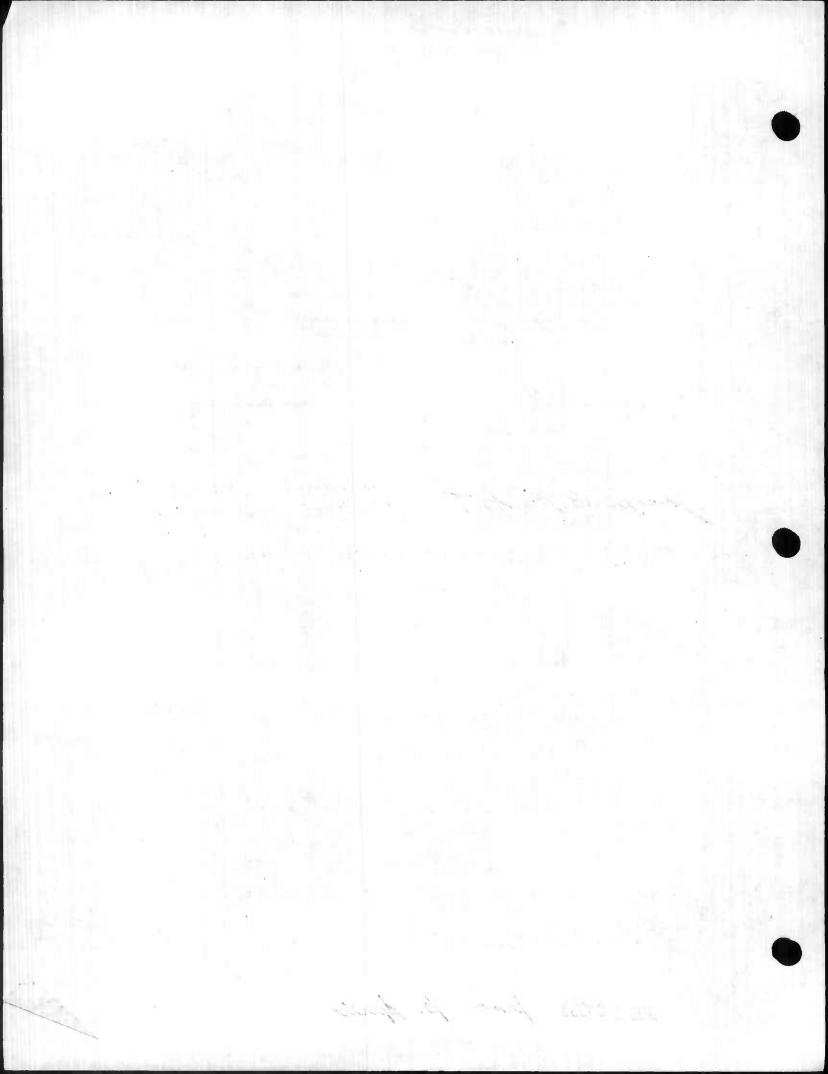
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima ol Death **Physician** sall uly -am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Beath 4c. County of Death Examiner Lorien Nursing Center Columbia If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** 10M 20F Months Days Hours Min. Yrs. 216-18-7531 Director 81 Jan. 18, 1918 Maryland Usual Residence of Decedent permit. Pegas 1 and 2 should be filled within 72 hours after death with the Menyland Department of Health and Mentel hygiene. Important: If Item 27 is marked other than "natural", or hems 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7080 Cradle Rock Way 21045 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?unknown 1 □Yas 2 □ No IYas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white Š 3 StWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) unknown 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom Stata 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Joseph Ba Van Sant State Anatomy Board, 655 W. Baltimore Street 23a. Part1. What the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** Immediata Cause (Finat disease or condition resulting in death) /Medical RBNAL FAILURE CHRONIC Examiner PERTENSION Examiner Jean ettending physician and for use as the burief-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760 deeth certificate be Physician/Medical Dua to (or as a consequence of): P.O. | 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown obstructive Pulmonary Discose Records, þ 24b. Ware autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed · OFIY ROIDISH 1□Yas 2♥ No 2 1 No Division of Vital 25. Was case refarred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: A Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 No 2 this funeral 27. Mannaf of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After 1 Natural Attending ours effector: An. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral D completely filled The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and utle of certifier 29c. License number 29d. Data signed (Month, Day, Year) D 304-69 5 k. rson who completed cause of death (Item 23a) (Type, Print) PRIVE: \$100: 6134 27042 31. Data filed (Month, Day,

DHMH 16 Rev 6/95

State Registrar

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** 1999 SATTOR الال 24 8: 25 PM 211,20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Nema (If not institution, giva street end number) Examiner If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) ALTH OF BIL AIR HARFOR ARINER If Under 1 Yeer Birthplace (Steta or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 LF Months Days Yrs. 1186 84 816 JARY' Usuel Rasidance of Decedant 10a. State 10b. County 10c. City. Town or Location 10d. tnside City Limits 1 Yas 2 No Directo MARNAMO HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? V.S.A 3011 SAC 21015 Funeral 14. Rece - American Indian, 12. Was Decedant Evar in U,S. Armad Forces? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 11. Maritel Status Black, Whita, atc. 1 ☐ Yas 250 No If Yas, Give Yeer or Datas: 1 Never Merried 28 Merried 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada completed) Elemantary/Secondary (0-12) College (1-4or 5+) EERE IARIAL 127RS 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) Be PASTORDAD HOU HOUY 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Raletionship (Type, Print) BURIR, MARYLAND 3011 SANDY looks III. 20b. Piaca of Disposition (Nama of cematary, cramatory or other place) Data プレンプレ 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State BIT HILL BUT 4 Donation 5 Other (Specify) 22. Nama end Addrass of Facility 21. Signature and eral Se Air 459,19 EVANS FUNERAL 23a. Part1. Enter tha di eese, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or haert failure. List only one ceuse of each line. FOREST 1ARYLAND Approximata tntarvsl Batween Onsat and Deeth 10 days Immediate Causa (Final disaasa or condition rasulting in daath) Urosopsis Due to (or as a consequence of): Examiner Sequantially tist conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury thet initieted avants rasulting in daath) Last Dua to (or as a consaquance of): Physician/Medical Dua to (or as a consequance of) Part ff. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Dfd tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes Maltiple Sclerosis þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performad? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Assidance 6 Othar (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Dath 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specity) 4 Homicida 29a. Cartifiar (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) Medical and manner statad. 29d. Dete signed (Month, Day, Year) 29c. License number D34652 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

2 North

32. Registrar's Signatura

Avenue

Bel Air Manyland 21014

inoutasze - montes, Lucille State Registrar

DHMH 16 Rev 6/95

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Mod cal Examinar must be notified at

filed within 72 hours after death Hygiene.

2 should be f and Mental I

Pages 1 and 2 s ment of Health an ant: If Nem 27 la 1

permit. Pages Depertment of Important: If It any injury or o

Physician

/Medical

Examiner

ettending physician end for use as the burial-transit

signed by

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or Attending Physician:

the funeral director.

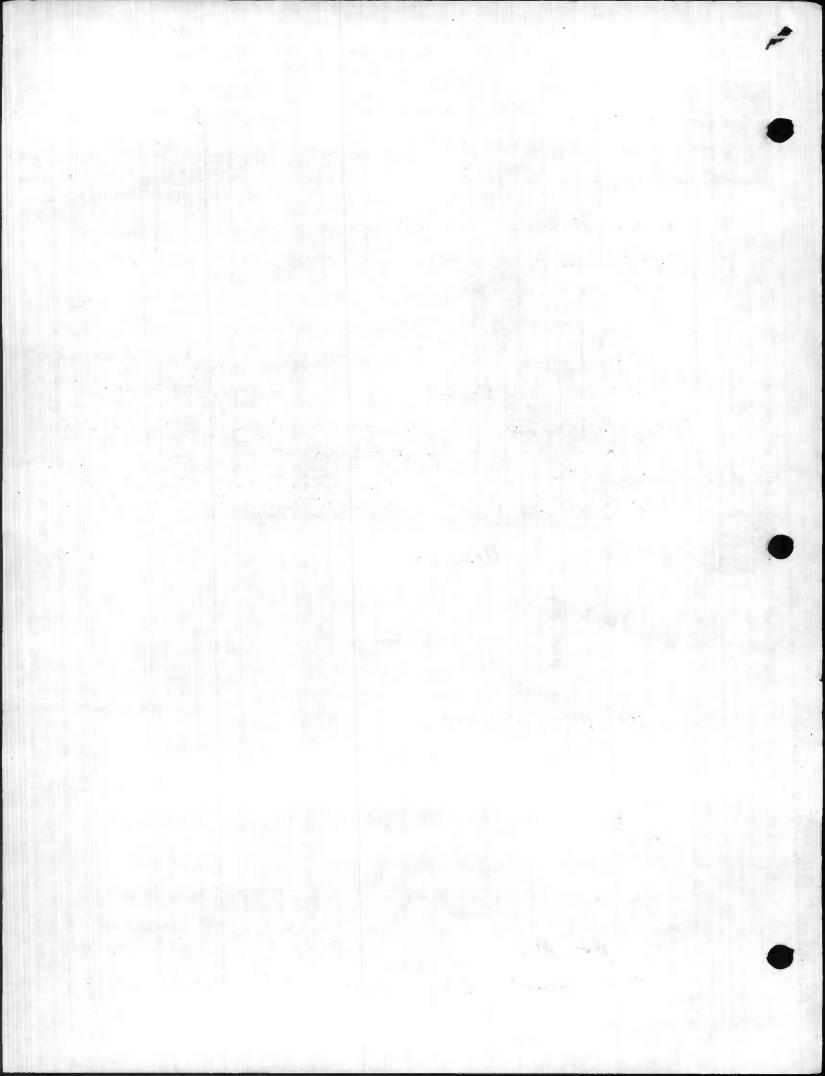
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completely

31. Data filed (Month, Day, Year)

certificate be

Baltimore, Maryland 21215-0020



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q 2 7 2 8

				Certifica	te of	Death		Reg. No.	10 6	20120		
	1. Decedent's Name (First, Middle, L.	est)	7.79	1.00.60			2. Date of D		Year	3. Time of Dear		
Physician /Medical	George H.	O'Ro	ourke				6	26	99	4:50 p		
Examiner	4e Facility Name (If not institution, gi	ve street and number	r)			4b. City, Town,	or Location of Dea	ath 4c. Cou	unty of Death	1		
	EDENWALD					Towso	n	Ba	ltimor	e		
Funeral			ige (In yrs. last bir	thday) If Und	er 1 Yea		in (Month I	Birth Day Yearl	9. Birth	place (State or For		
Director	212-05-4748	15XM 2□F	92	Yrs.	Days	Tiodis N	Sept.2	7, 190	6 Mar	yland		
p .	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location											
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oto cto	Maryland Baltim	ore	Tows	on						1 ☐ Yas 2🖎		
with the Ma n or 28a-f a be nothrea	10e. Street and Number				10g. Citizen	of What Cou	intry?					
death with the Maryland rms 23a or 28a-f show rms to a notified at neral Director	800 Southerly Ro	ad, Apt. 9	909		21	204		U.	S.A.			
ifter death v r frame 23s niner must Funeral	11. Merital Stetus	12. Wes Deceden Armed Forces	t Ever in U,S.	13. Wea Dec	edent of ecify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	14.1	Race - Ameri Black, White			
ate and IT	1 Never Merried 2 Merried	1 ☐ Yes 212 If Yes, Give		1□ Yes			Sylve Site.					
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nple and	Elementery/Secondary (0-12)	College (1-4or	5+)			during most of a			more G			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygione. Important: If fem 27 is marked other than "natural", or frame 23s or 28s-f show any injury or other traumatic avent, the Medical Examinar must be nothed a once. To Be Completed by Funeral Director	12	0		Photo	gra	1			ctric	Co.		
	17. Father's Neme (First, Middle, Las		18. Mother's N	leme (First, Midd	le, Maiden Sun	name)						
To the	George W. O'Rourl					Boettger						
pue el	19e, Informent'a Neme/Retetionship		19b	. Meiling Addre	ss (Stree	at end Number or	Rural Route Num	ber, City or To	wn, State, Zi	ip Code)		
of Health	Clewell Howell/ex	recutor				t., Tows	on, MD	21204				
	20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 [The moved from State	comete	Disposition (No. 1), cremetory or	other pl	ace)	Date	20c. Location	on - City or T	own, Stete		
mut: h	4 Donation 5 Other (Speci											
Department of the control of the con	21. Signature of Funeral Service Lice					ress of Facility						
SSESS	Joseph	By San 8a	nt L					W. Bal	Ltimor	e Street		
	23a. Part1. Ent -r the disease, or con shock, or heart feiture. List only	polications that cause	ad the deeth. Do			e, MD 2		arrest.	- 5	Approximate		
Examiner Laurent Laure	disease or condition resulting In deeth) Sequentially list conditions,	b	Due to (or es a):		Ancin					
ng physician and as the burial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Laat Due to (or as a consequence of):											
		d							<u> </u>			
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be de by P												
bould hould							24a. Wa	as an autopsy formed?	8'	Vere autopsy findin vailable prior to completion of cause f death?		
ata has b page 2 st							10	Yes 2011	5 1	☐ Yes 2☐ No		
ertifical ector. p	25. Was case referred to medicat					26. Place of I	Deeth (Check only					
0 2 0	axeminer?	Hospitel:	ient 2 ER/Qu	toatient 3 7 r	O AO	thee	Home 5□Re		Other /Sner	offv)		
25 60	27. Menner of Death	28a. Dete of Inj (Month, D		ime of	28c. Inj			e how injury oc				
or death. Sctor: After by the fune	1 Netural 5 ☐ Pending 2 ☐ Accident Investigation		ay Year)	njury M		ork? ☐Yes 2☐No						
5 E C	3 Suicide 6 Could not be determined			(Street and No	umber or Rui	ral Route Number,						
within 24 hours at To the Funeral Di completely filled ii	29a. Certifier 12 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis of end menner s	of examinetion an	, deeth occurre d/or investigetion	d et the t	time, date and pla opinion, death oc	ace, and dua to the coursed at the time	e cause(s) and e, date and pla	d manner as ice, and due	atated. to the cause(s)		
Within comp	29b. Signature and Ittle of certifier	20		1		nse number		29d. Dete si	igned (Month	, Day, Year)		
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	20 Name and add	ann alatest account of	door the control					,		,		
(0	30. Name end address of person who				Т-4	nthicum	MA 210	90				
M	Dr John Shavers			ue koao	لىل وا	LIICHICUM	, rid 210	<i>,</i> 0				
State	31. Date filed (Month, Dey, Year)		trer's Signature	/	,							

ETHEL M. PRICE

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State of Maryland / Department of Health and Mental Hygiene

Department	011	icanii and	IVIC
Cartificate	of	Dogth	

Deya

Physician
/Medical
Examiner

1. Decedent's Neme (First, Middle, Last) ETHEL M. PRICE 4a Facility Name (If not institution, give street and number)

JULY 4b. City, Town, or Location of Death

3. Time of Death Day Yeer 11:32 AM 1999 21, 4c. County of Death

Funeral

2500 WEST BELVEDERE AVENUE APT. #514 5. Social Security Number 7. Age (In yrs. last birthday)

BALTIMORE

If Under 1 Year | If Under 24 Hrs. Dete of Birth (Month, Day, Year) 9-14-1922 Birthplace (State or Foreign Country) Hours

Reg. No.

2. Date of Deeth

Month

212-28-6914 Usual Residence of Decedent 1 M 2 A F 76

NC

10d. Inside City Limits

Director

r than "natural", or items 23s or 28s-f show the Medical Exempler must be notified at

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiena. Int: If Itam 27 Ia marked other than "natural", or ite

other Ham

= 8 Department of Important: If any injury or page.

Baltimore, Maryland 21215-0020

10a. State 10b. County MD.

10c. City, Town or Location BALTIMORE

1 Yes 2 No

10a Street and Number APT# 514

2500 BELVERDERE AVE.

10f. Zip Code 21215

Months

10g. Citizen of What Country? U.S.A.

11. Marital Status

1 Never Married 2 Merried 3 Widowed 4 Divorced

12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Detes:

 Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify

14. Race - American Indian, Bieck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry PRIVATE DUTY

17 Father's Name (First Middle I ast)

FRED LITTLE

18. Mother's Neme (First, Middle, Maiden Surname) MARY L. SAVAGE

Date

19a. Informant's Name/Relationship (Type, Print)

NURSE

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

JOHNNY PRICE

20a. Method of Disposition

301 McMECHEN ST. BALTIMORE MARYLAND 21217 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

h☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

GARRISON FOREST CEMETERY 7-27-99 OWINGSMILLS MD.

22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A.

21. Signature of Figneral Service Licensee

1300 EUTAW PLACE BALTIMORE MARYLAND 21217 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cardiac or see on each line.

Physician /Medical Examiner

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physician s the buria

50

page 2 a has

certificata

this funeral

After

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completely

s after death.

within 24 hours a To the Hospital

98 980

The law requires that the death certificata be executed

Box 68760.

P.O.

Records,

Division of Vital or Attending Physician: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

Arteriosclerotic	Cardiovascular	Disease
Due to (or es e conse	equence of):	

Due to (or as a consequence of):

Due to (or es a consequence of):

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 | Yaa 2 | No 3 | Probably 4 | Unknown

24e. Wes an autopsy performed?

24b. Were autopay findings available prior to completion of cause of death?

Approximate Intervel Between Onset and Deeth

INSPECTION

1 Yes XX No

1 Yes 2 No

25. Was case referred to medical examiner? XYes 2 No

5 Pending investigation

6 Could not be determined

1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Dey Year) 28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

3 DOA

Other: 4 Nursing Home XX Residence 6 Other (Specify) 28d. Describe how Injury occurred

26. Place of Death (Check only one)

29e. Certifier (Check only one)

27. Manner of Death

Netural

3 ☐ Suicide

2 Accident

4 ☐ Homlcide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) JULY 21, 1999

28f. Location (Street end Number or Rural Route Number, City or Town, State)

work

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

O.C.M.E

THEODORE

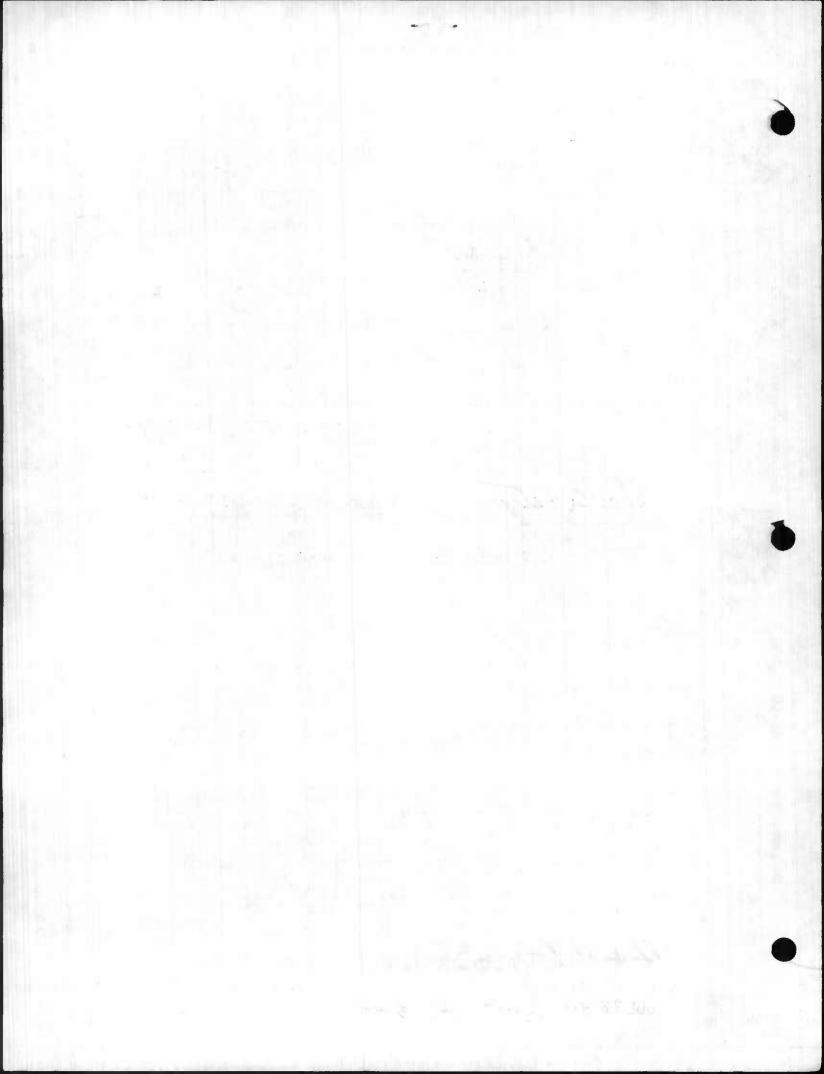
32. Registrer'a Signature

che

Hospitel:

State Registrar

DHMH 16 Ray 6/95



ADH AVON POPE

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

99-3716- AMEND ITE		0 #23 PART I	, 27 PER										fental H	ygier Reg. 1	90	3 23	37	30
Physic /Medi	ian	Decedent's Nama (First, Middle, Last) Avon Pope										2. Data of D Month JUNE	Desth	Day Year 3.			ne of Death	
Exami		4a Facility Name	(If not institutio	n, give street and	d number)						4b. City, To	wn, or L	ocation of Dea	ath 4	4c. County	of Desth		
4		MARYLA	ND GENE	ERAL HOS	PITAI	L	BALTIMORE					E CITY						
Funeral Director		5. Social Security I unknown	Number	6. Sex 1 2M 2		Age (In yrs. last birthday)			If Under 1 Year Months Days			24 Hrs. Min.	8. Data of E (Month, L Jan.	Birth Day, Year)		Birthplace (Stata or Foraign Country) unknown		
2	0	Usuat Residence of Decedent																
death with the Maryland ms 23a or 28a-f show me 13a be notified at	tor	10a. State 10b. County 10c. City, Town or Location unknown unknown unknown																Yas 2□No
# 28 P	Director	10e. Street and Number							10f. Zip	Code				10g. 0	Citizen of	What Countr		
ath with		unknown unknown											nown					
urs effer	by Funeral	11. Marital Status Unknown 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? Un 1 Yes, 2 No If Yes, Give Year or Dates:					wn	H.	as Deced Yes, spec Know Yes	cify Cub	an, Mexica	n, Puerto	ecify Yes or N Rican, etc.)	10-	Bls	ce - Amarica ck, White, et y: male	tc.	in,
A 1 A 1 3-00 A 0 4 Within 72 hours of jiene. Them "neturel", or the medical Error	eted	15. Decedent's Education (Specify only highest grade completed)				16a. D	Give k	ind of wo	al Occu	pation during mos	st of work	ing	16b.	Kind of B	usinass/Indu	/industry		
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and 2 sho alth and N 27 is ma		19a. Informant's N	lame/Relations	ship (Type, Print)			19b. I				t and Numb	er or Rur	ral Route Num	ber, Cit	y or Town	, Stata, Zip C	Code)	
Health and 2 Health and 27 he wither trace		unknown				1			know									
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permit. Pages 1 en Department of Heal Important: If Item 2 any Injury or other pings.		21. Signature of F	t -	22. Name and Address of Facility State anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201								ceet						
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Physician /Medical Examiner	Н	Immediate Cause disease or conditi- resulting in death)	on	BRO	NCHOPN	NEUMONI	Α									1		
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oate be assected physician and the burlei-transit	Examine	Sequentially tist coil sny, leading to it cause. Enter Und	onditions, mmediata erlying	5 b		Dua to (or	as a co	nsequ	ence of):									
certificate be assecuted iding physician and iss as the burlei-fransit	Medical	Cause (Disease or that initiated event resulting in death)	8	c	{	Due to (or	as a co	nsequ	ence of):									
deeth defort	Physician/M	Part II. Other signi	ficant condition	ons contributing	to death be	ut not resul	ting in t	the unc	dertvina c	ausa ni	ven in Part	1.	23b. DI	d tobac	GO USO GO	ontribute to	the ca	use of death?
es that the deeth certification by the attending place deteched for use as t																3 ☐ Probe		Unknow
raquir been should	Completed by												24a. Wa	is an au formed		avai	lable ;	psy findings prior to n of cause
The lew cate has	Com												مها	Yes	2□No			2 No

To the Hospital or Attanding Physicien: The law requires th within 24 hours after death.

To the Funerel Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be on Division of Vital Records.

27. Manner of Death 1 Natural

25. Was case referred to medical examiner? Hospital: Ampatient 2 ER/Outpatient 3 DOA XX Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

My

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one)

2 ☐ Accident

3 ☐ Suicide

4 Homicide

Medical Certification: To Be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X PMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Molyma

29c. License number OCME

29d. Date signed (Month, Day, Year) JUNE 30, 1999

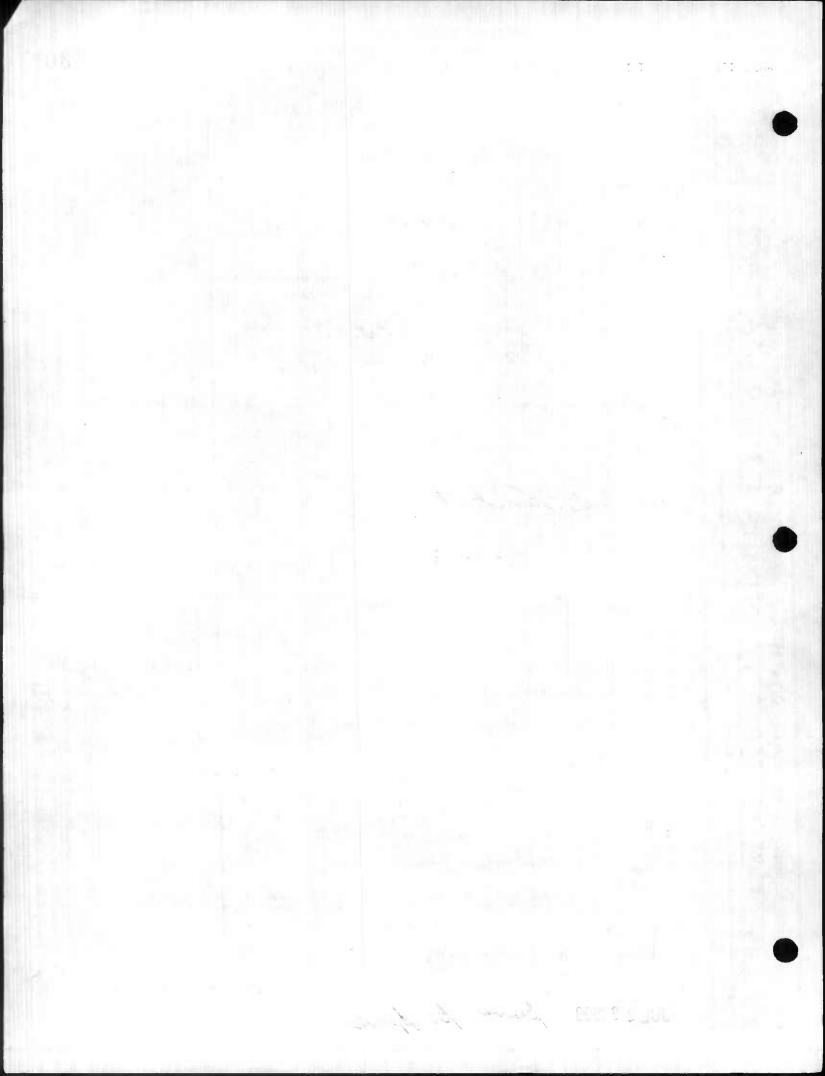
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)
JUL 2 8 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

23731

NOVAT	PRICE

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

2. Date of Death Day Month JULY

Reg. No.

3. Time of Death

The law requires that the death certificate be executed **burial-tran** Box 68760. use as the P.0. Records, 8 388 page 2 certificate of Vital Physician: this Division

Year 0228 AM TAVON HOWARD PRICE 1999 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A JOHNS HOPKINS HOSPITAL If Under 24 Hra. If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthpiace (State or Foreign 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months Hours 10 M 2 F 21 02 - 08 - 78BALTÓ. Director 213-92-0011 MD Usuei Residence of Decedent the Maryland 10a. Stete 10c. City. Town or Location 10b. Count 10d. Inside City Limits ahow ns 23a or 28a-f show MD N/A BALTIMORE 1 Yas 2 No Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 1400 POPULAR GROVE ST 21216 U.S.A. Funeral 12. Wea Decedent Ever in U,S. Armed Forces? 1 ☐ Yea 2 ☐ No If Yes, Give Herna 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Merried 6 21215-0020 1 ☐ Yes 2 No Specify: BLACK Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainass/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 9th UNKNOWN UNKNOWN Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Meiden Sumame) s 1 and 2 should be fill Health and Mental H tam 27 Is marked off Be JAMES E. PRICE SR THELMA ROWLETT 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a Itam 27 Is other tra THELMA ROWLETT, mother 821 FREMONT AVE, BALTO. MD 21216 ace of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 etery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State = b Department of Important: If any injury or TOU NT ZION 7-30-99 BALTO. MARYLAND 4 ☐ Donation 5 Other (Specify) 21 Signature of Fu neral Service Lice 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 e carried the Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting In death) Examiner . Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or es e consequença of): Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use centribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yes 2□ No 25. Was case reterred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To XX Yes 2 No 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA funeral 27. Menner of Death 28a. Dete of Injury Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 28c. Injury at Work? Attending 5 Pending investigation 1 Netural s after death.

Director: After in by the fur 99 2230 1 Yes 2 No was 20 2 Accident Jubi 281. Location Street end Number or Rural Route Number, City or Jown, Stele)

Bultimore, N 3 Suicide 6 Could not be determined Plece of Injury - At home, term, street, factory of building, etc. (Specify) filled in by Homicide Street Front of 1226 Ars a with St. But imore 1 Certifying Physician: To the best of my knewledge, deeth occurred at the time, dete end place, end due to the cause(s) and mannar as stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and mannar stated. ó To the Hospital o within 24 hours af To the Funeral DI edical 29a. Certifler (Check only one) 29b. Signeture and title of eartifier 29c. License number 29d. Dete signed (Month, Day, Year) O.C.M.E JULY 22, 1999 rson who completed cause of deeth (Item 23e) (Type, Print) 30. Name and addr estame(111 Penn Street, Baltimore, Maryland 21201 0

DHMH 16 Rev 6/95

State Registrar

31. Date filed

28 1999

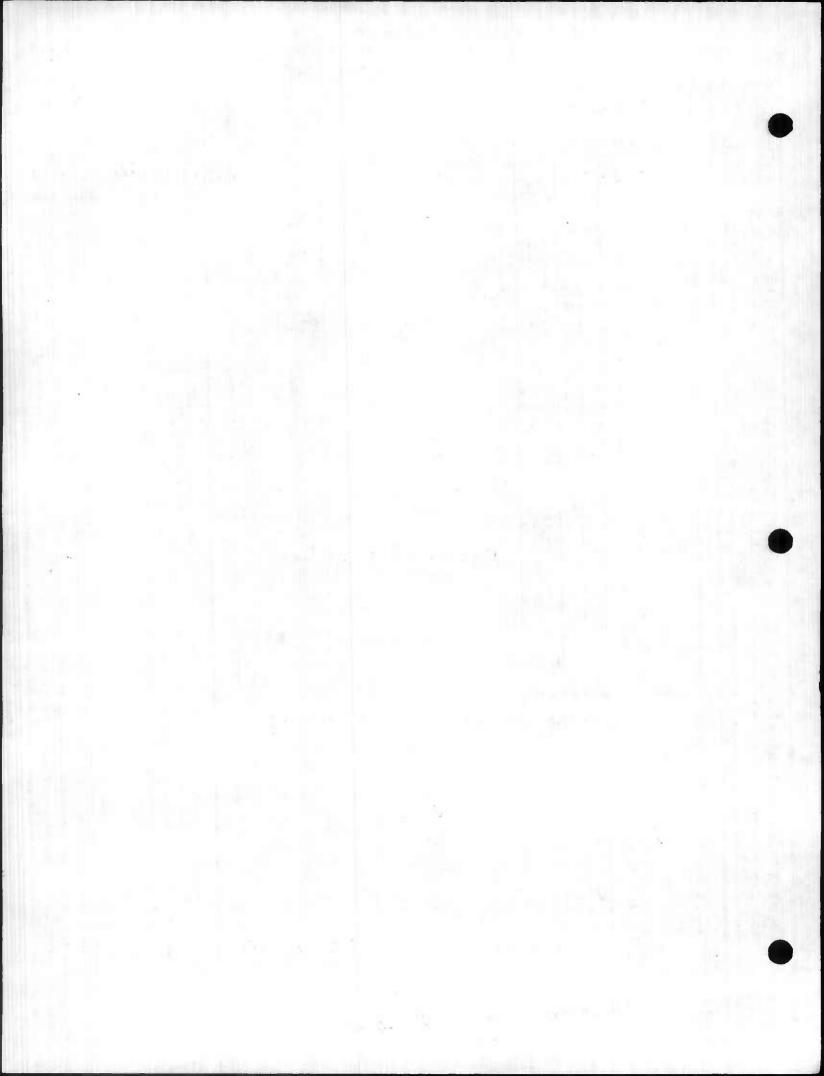
32. Régistrer's Signatura

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 9 23732

		Certifi	cate of Death	F	Reg. No.	0102
Dhysisis	Decedent's Neme (First, Middle, Last)			2. Dete of Dea Month		3. Tima of Death
Physiciar /Medica	HDECAIDE ELLEN			JULY	26 199	9 9.5494
Examine			4b. City, Town, or I		4c. County of Dea	1/1
Funeral	5. Social Security Number 6. Sex	7. Age-fin vrs. last birthdey) If I	Under 1 Year If Under 24 Hrs.	10RECIT		tholace (State or Foreign
Director	218-10-6640 1 M 2XF	93 yrs. Mo	onths Days Hours Min.	6. Dete of Birth (Month, Day	9,7905 Ma	thplace (State or Foreign Suntry)
nylan ahow	10s. State 10b. County	10c. City, Town or Locatio	n			10d. Inside City Limits
vith the Ma t or 28s-f a	Maryland N/A	Balt	imore			1 ⊠yes 2 No
ath with th	10e. Sfreet and Number 2500 Be UEC	tere Aue.	21215		10g. Citizen of What Co	SA
and 21215-0020 be filed within 72 hours after death with the Maryland hall Hygiene. diction than "natural", or frems 23e or 28e-f show avent, the Madical Exeminer must be notified at	3 Widowed 4 Divorced If Yes, Giv	2 No 1 1	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puert res 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Bleck, Whit	
21215-0 ed within 72 ho ygiene. her than "naturn ft, the Wedle	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's (Give kind	Usual Occupation of work done during most of wor IOT use retired)	king	16b. Kind of Business	Industry
121	Elementery/Secondary (0-12) College (1	-4or 5+)	OT use retired)		School	Cucton
N Post		Lau	18. Mother's Ner	ne (First, Middle,	Maiden Sumeme)	System
Vianc wid be fil Mental H inked off		ffin	Cler	netir	ne, CN	idrov
Maryiand 212: d 2 should be filed within th and Mental Hygiene. T is marked other than traumetic avent, the Hy	19a Informant's Name/Relationship (Type, Print)	(SOM) 19b. Mailing Ad	Idress (Street and Number or Ru	yal Route Numbe	r. City or Town, State,	Zip Code)
N alth	Mr. John L. Keed	Jr. 1741	Waverly W	ay c	Balton	Md.21239
0 = 0 = 0	20a. Method of Disposition 1 Depurial 2 Cremetion 3 Removel from 5 4 Donetion 5 Other (Specify)	Stete 20b. Plece of Disposition femelery, cremator	y or other plece)	8/2/99	Balto.	Town, State
Baitim permit. Pag Department Important: I any injury o	21. Signature of Funeral Service Linesee	P Jos	me en Address of Facility	s Fur	ieral, Ho	me
	23a. Part1 E ter the diseet , or complications but or shock, or heart feilure / List only one cause on ea	aused the deeth. Do not enter the	mode of dying, such as cardiac	or respiratory are	rest,	Approximete Interval Between
Physician	0 0		^			Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	My o cardial 1	nfarction.			40mts.
		Due to (or es a consequenc	(lo ec			
axecuted and tal-transit	Sequentially list conditions	Due to (or as a consequence	e of):			
68760, ifficate be assected g physician and as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
68760, ficata be an physician as the buria	that infliated events resulting in deeth) Last	Due to (or es a consequenc	e of):			
5 00				4111		
Box eath cert attendin sfor use		and the second s	The second section is Board	005 0144	-h	A- M
Cords, P.O. Box v requires that the death cen been signed by the attendin should be detached for use	Part II. Other algnificant conditions contributing to de					robebly 4 Unknown
		Sinus Syndron	e Coronary			
Vitai Records, siden: The law requires the certificate has been signe rector, page 2 should be on the commission by	and diegon	•		24a. Wes a perfor		Wera autopsy findings available prior to
law r	orteny Ms and				1/	completion of cause of death?
Vital Re- ician: The lay certificate has rector, page 2				1 🗆 Y	es 2000	1 ☐ Yes 2 ☐ No
Vision of Vita Attending Physician: r death. ector: After this cartific by the funeral director,	Hospital		Other:	ath (Check only or		
Phys critis	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	of Injury 28b. Time of	28c. Injury at Work?		ence 6 Other (Spe ow injury occurred	ecity)
ion nding ath. :: Afte e funde	1 Netural 5 Pending (Month 2 Accident investigation	h, Day Year) Injury				
Division of tall or attended to the formal of the funeral died in by	3 Suicide 6 Could not be determined 28e. Place buildin	of Injury - At home, farm, street, fing, etc. (Specify)	actory, office	28f. Location (S City or Tow	treet and Number or R n, Stete)	ural Route Number,
Division of To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral display Addition Confidential Cartification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the land menn	isis of examination and/or investig	urred at the time, dete and place pation, in my opinion, death occu	, and due to the c rred af the time, d	ause(s) and manner a lete and place, and du	s stated. e to the cause(s)
To the To the comp	29b. Signeture and fittle of certifier		29c. License number		29d. Data signed (Mon.	th, Day, Year)
	laris, when mo		D0021730		July 3	16 1999
	30. Name and address of person who completed ceuse	A			0	
	TARIA KHAN.	SINAI HOSPIT	TAL			
State	31. Date filed (Mogiff, Day Year) 32. Re	egistrar's Signature				

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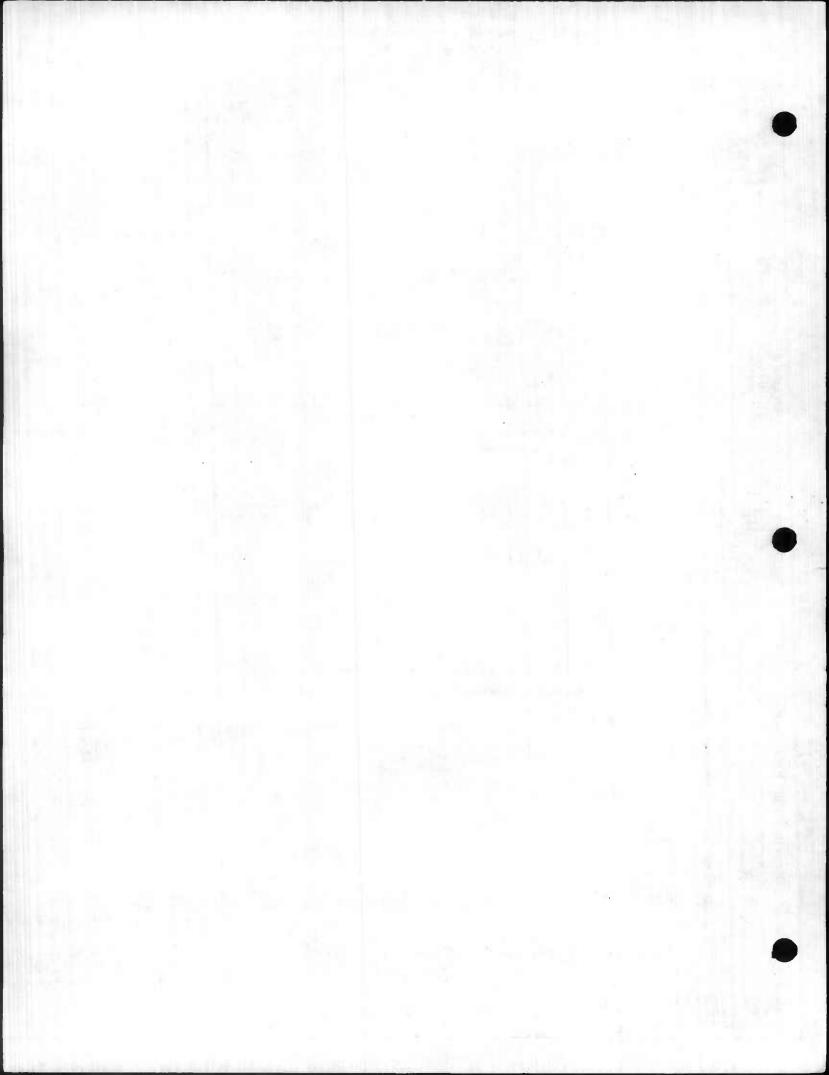


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Dete of Death Day Month **Physician** 6:35 A.M MARIE 4b. City, Town, or Location of Seath 24 ROWE ANNA 1999 /Medical 4a Facility Nama (If not Institution, give street and number) 4c. County of Death Examiner CENTER HOSPITAL BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign Country) **Funeral** 1□M 20 F Months 214-12-2938 90 Director May 03 1909 Maryland Usual Residence of Decedent the Maryland 10s State 10b Count 10c City Town or Location 10d, Insida City Limite tem 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examinar mast be notined at Md. n/a Baltimore 1 Yas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 USA 2603 Northshire Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 247 No If Yes, Give A Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indian. Black, Whita, atc. 72 hours after 1 Nevar Married 2 Merried permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or I any injury or other traumatic event, the Medical Exemples. Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C&M Hosiery operator 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Be Mary Vogel James McAdams 19e. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) William Bennett (Grandson) 231 Wanda Road, Pasadena, Md. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2/Cremetion 3 Removal from State Glen Haven Memorial Park 7/28/99 Glen Burnie, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 21. Signature Full eral Service Licensee 23a. Part1. Exter the disease, or complications raticely add the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neer tellure. List only one cause of each fine. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final FAILURG HEART 4 DAYS disease or condition resulting in deeth) CONGESTIVE Examiner Due to (or as a consequence of): Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Box 68760. attending physician for use as the buria that the death certificate be Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yae 2 No 3 Probably 4 Unknown Records, by 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? peeu 2 100 1 ☐ Yes 2 No Division of Vital 25. Wes case referred to medical axaminar? Be 26. Place of Deeth (Check only one) Hospitel: 1 Dimpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) To the Hospital or Attanding Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the causa(s) end menner as etated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) M.D 30. Name and eddress of person who completed cause of death (item 23a) (Type, Print) 3001 S. HANOVER ST. BALTIMORE, MD BOBAT ISMAIL 31. Date filed (Month Pay, Year) 32. Registrer's Signature State 1999 Registrar

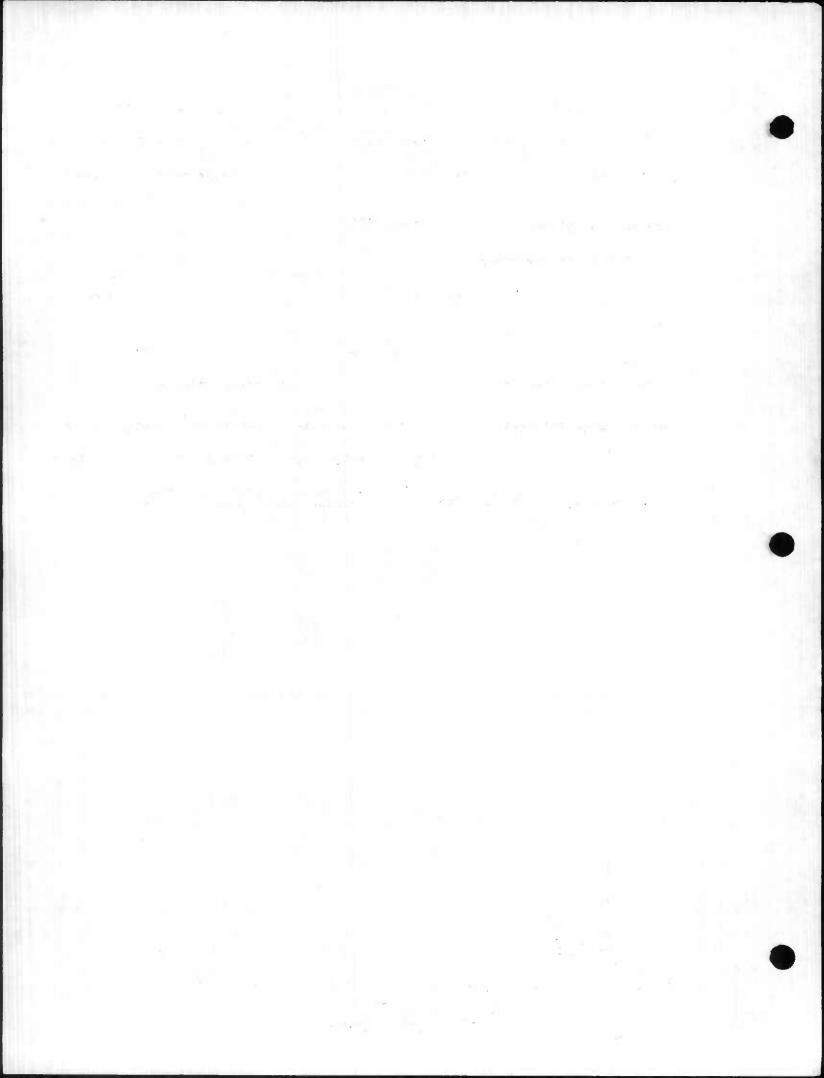
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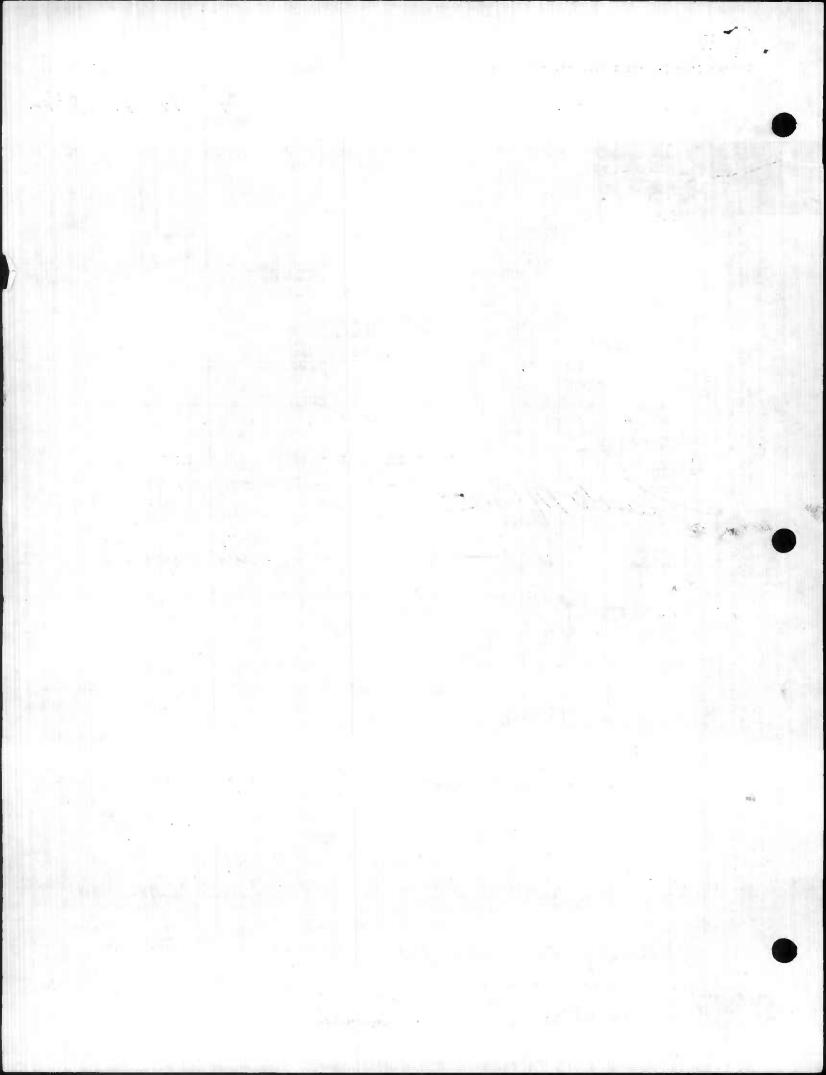
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Mental Hy Certificate of Death	ygiene 99	23734						
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	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 1. Age (In yrs. lest birthd	70	9. Birthpiace (State or Foraign Country) Mass.						
	fand		Usuel Residence of Decedant 10a. Steta 10b. County 10c. City, Town or Location		10d. Inside City Limits						
	a-fah	tor	Maryland Baltimore Cockeysville		1 ☐ Yes 2 ☐ No						
	or 28	Director	10e. Street and Number 10f. Zip Coda	10g. Citizen of Wh	nat Country?						
	ne 234	Funeral	10521 Wil-Mar Place 11. Meritel Stetus 12. Was Decedant Ever In U,S. 13. Wes Decedent of Hispanic Origin? (Specify Yas or N	U. S.	A American indian.						
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Manyland Health and Mental Hygleno. tam 27 la marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Examinet must be notified at	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Detas:	Specify:	, White, etc. White						
15-0	netur	eted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Bus	iness/Industry						
212	filed withir Hyglene. ott, the Went,	Completed	Elementery/Secondary (0-12) College (1-4or 5+) Manager	Offic	ce						
	tal Hyg d other avent,	BeC	17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Last))						
Maryland	should be and Mentai i marked o umatic ave	To	Ruth Sigred F								
Ma	and 2 sho baith and n 27 is me		19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Num Ruth P. Hayes (Sister) 6209 Elmbank Ave., Baltimor		,						
ore,	of Health Itam 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of Dete		City or Town, State						
Baltimore,	Pages ment of I ant: If its ury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 7-29-99	Towson	, Maryland						
Balt	permit. Pages 1 and Department of Health Important: If Itam 27 any Injury or other tr once.		21. Signeture of Funeral Service Licensee 22. Nama end Addrass of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204								
			23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory shock, or haert feilure. List only one cause on each line.	arrest,	Approximate Interval Between Onset and Deeth						
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		5 clays						
Ļ	RESIDENCE OF STREET	ner	Due to (or es a consequence of): Distress Syndrome	(ARDS)	2 days						
	and Hrans	Examiner									
68760,	icate be executed physician and s the burial-transit	edical E			Syears						
Box 68	eath certificat attending phy I for use as the										
	death he atte	Physician/M	Part ii. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did	d tobacco use cont	ribute to the cause of death?						
s, P.O.	res that the de signed by the a be detached (by Phy		Yee 2 No :	3 ☐ Probably 4 ☐ Unknown						
Division of Vital Records,	aw requi	Completed		s en autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?						
al R	E se F			Yes 2 No	1 🗆 Yes 🛂 No						
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Divis	To the Hospital or Attanding Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funera	Certification:	3 Suicide 6 Could not be determined 4 Homicide 28e. Plece of Injury - At home, farm, streat, factory, office 28t. Location City or To	28t. Location (Street and Number or Rural Route Number, City or Town, Stete)							
	Hospi 24 hou Funer tely fill	edicai		a cause(s) and man	ner as stated. nd due to the cause(s)						
	o the	Med	≥ 29b. Signature and title of certifier// 29c. License number		(Month, Day, Year)						
	r s r ö		P11753:	7/25/	99						
	6X/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Goodman, MD BVAMC 10 N. Greene St. Ba	11.	40 2124						
	, Sto	•		Itimore /	10 7 110/						
	Sta Registr		WW 00								



AMEND ITEM: #20A PER DB EW. Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. AMEND ITEMS: #208-C G774 8-3-99 wState of Maryland / Department of Health and Mental Hygiene Amended Item#23apt1A PERPhyG773 7/28/99 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dele of Death 30 Month Physician Nora Lee Rogers 17 99 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Magnolia Gardens Lanham H Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month Day, Year)
Feb. 14, 18 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Months 284-36-1729 81 Yrs. Arkansas Director **Usual Residence of Decedent** 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Md. PG X□ Yes 2□ No Director ma 23a or 28a-f a Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8110 Goodluck Rd. 20784 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 XNo If Yes, Give Year or Dates: Neme Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No 8 Specify Specify Black þ XDWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiena. Elementary/Secondary (0-12) 7th College (1-4or 5+) Domestic Worker .. Pages 1 and 2 ahould be flied w tment of Health and Mental Hygler tant: If Item 27 Is marked other th ilury or other traumatic avent, the Maryland 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Unknown Letha Williams 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Herman Rogers (Son) 4207 74th Pl. Lanham Md. 20784 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or page FOREST HILLS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 7/28/99 CLINTON MD. 22. Neme end Address of Fecility
Tri-State Funeral Services, Inc. 21. Signature of Euneral Service Licenses 814 Upshur St NW Wash. DC. 23a. Part Liter he disease, or com shock, or heart teilure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, only of a cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediete Cause (Final disease or condition resulting in death) erebro vastalan Examiner Examiner andio vascular The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) es a consequenca of) one week traut intech Physician/Medical signed by the attending to be detached for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed in demente certificata has arina tract in tection 1 Yes 2 No 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No alta funaral 27. Manner of Death 1 Natural 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftari Division 5 Pending investigation I or Attending after death. Director: Aft 1 Tyes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the 3 ☐ Suicide 28e. Placa of Injury - At home, term, street, tectory, office building, etc. (Specity) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/20/99 43446 Rouston Farahitan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mitchelle ville ward B216 BOWIE MD 20716 ROINTAN FARAHIFAR M.O. 4000 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State JUL 28 1999 ,wa Registrar



State of Maryland / Department of Certificate

of Health and Mental	Hygiene	9	9	2	2	7	2	C
of Death	Reg. No.	-	and .	Com	J	-	J	U

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timore, Maryland 21215-0020	. Pages 1 and 2 should be filled within 72 hours after death with the Maryland iment of Health and Merical Abritions	"natural", or items 23a or 28a-f show edical Examiner must be notified at	

ian	1. Decedent's Nama (First, Middle	, Last)		2. Deta of Deeth 3. Time of Death Month Dey Year						3. Time of Death		
ical	Fred Reece	Jr.							JULY	06. 199		3:47 PM.
iner	4a Facility Nama (If not institution,	_	ımber)				4b. City, To	own, or L	ocation of Death	4c. County	y of Death	
	513 E. 28th.	ST.					BAI	TIM	ORE			
	5. Social Security Number	6. Sex	7. Age (In yi	rs. last birth	nday) If Unde			24 Hrs. Min.	8. Data of Bir (Month, Da	th Iv. Yearl	9. Birth	place (Stata or Foreign
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	Usual Residence of Decedent											
	10a. Steta 10b. County		100.	City, Town	or Location							10d. Inside City Limits
Director	Maryland		В	altim	ore							1 No Yas 2 No
T T	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
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by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	iva Detes:		1□ Yas unknow		Specify:	:		Specif	y: wh	ite
8	15. Decedent'	s Education		16a [Decedent's Usu		pation			16b. Kind of B	lusiness/In	dustry
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9					10	unkn		VN r Rural Route Number, City or Town, Stata, Zip Code)				
	19a. Informant's Name/Relationsh	ilp (Type, Print)		19b.	Mailing Addrass	(Stree	t end Numb	er or Ru	rai Floute Numb	er, City or Town	, Steta, Zi	p Code)
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	20a. Method of Disposition	2 [] Damasial trans	206	. Place of I cemetery	Disposition (Na.	me of other pl	все)	- 1	Date	20c. Location	- City or T	own, State
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (Sp											
	21. Signature of Funeral Service Licensee 22. Nema end Addrass of Facility											
	Joseph	Dry Yan	Sant	1	atomy Board, 655 W. Baltimore Street							
	23a. Part1. Ent r the disease, or o	O. Jan	fee	ath Da	Baltim	ore.	, MD	2120)1			
	shock, or heert feiture. List of	only one ceuse on	eech line.	en. Dono	or enter the mod	ie of dy	mig, such as	cardiac	or respiretory e	rrest,	1	Approximate intervat Between Onset and Death
	Immediate Court (5'-1										1	-1100 E100 D0001
	Immediate Cause (Final disease or condition	. Atr	rerosc	lenot	Hic Co	ind	iovas	cul	rn Dis	1956		
	resulting in deeth)				onsequence of)							
Examiner												
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	Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Causa (Disease or Injury											
clan/Medical	I that initiated evants	C	Dua to	(or as a co	onsequance of):							
ē	resulting in death) Last		O02 (0	(31 d3 d 00	Juquanioo (I).							
7		d										
200									1			
YS	Pert II. Other algnificant condition	ns contributing to d	leath but not r	esulting in	the underlying o	ause g	iven in Part	t,		_		to the cause of death?
by Physi	Environment	al hu	prot	hror	nia				10	Yee ZENO	3 Pro	obably 4 Unknow
	Environmente Diabetes	1	F		117						1	
ופר	Dichetus								24a. Wes	an autopsy med?	a	Vere autopsy findings vailable prior to
Completed	DIAUTITS								Inca	ection	of	ompletion of cause f death?
E										Yes BEND	1	☐ Yes 2☐ No
Ф	25. Was case referred to medical						26 Plan	a of Dee	th (Check only o			
0	examiner?	Hospital:	Innationt 2	□ EP/O	patient 3 Do	0	Nh an		ome XX Rasi		her /Snen	íh/l
	27. Menner of Death	28a. Dete	•	28b. Ti		JA	4 🗆 14	wany n		how injury occu	rred .	,
-	4000	/Mor	th Day Year	Ini	inny	28c. Inju	ork?		e L'	1 4 400	cad	to high

Division of Vital Records, P.O. Box 68760. To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After completely filled in by the funer Medical Certificatio

2 Accident

5,

5 Pending invastigation 6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1□ Yes 2 No

environmental temporature Location (Street and Number or Aural Avunber, City or Town, Stete) 513 E, 38+h Street

| K-CS | drnc\ | Baltimore City, Maryland|

1 | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**EXMedical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) JULY 07, 1999

Stephen Si 31. Date filed (Month, Dey, Year) State

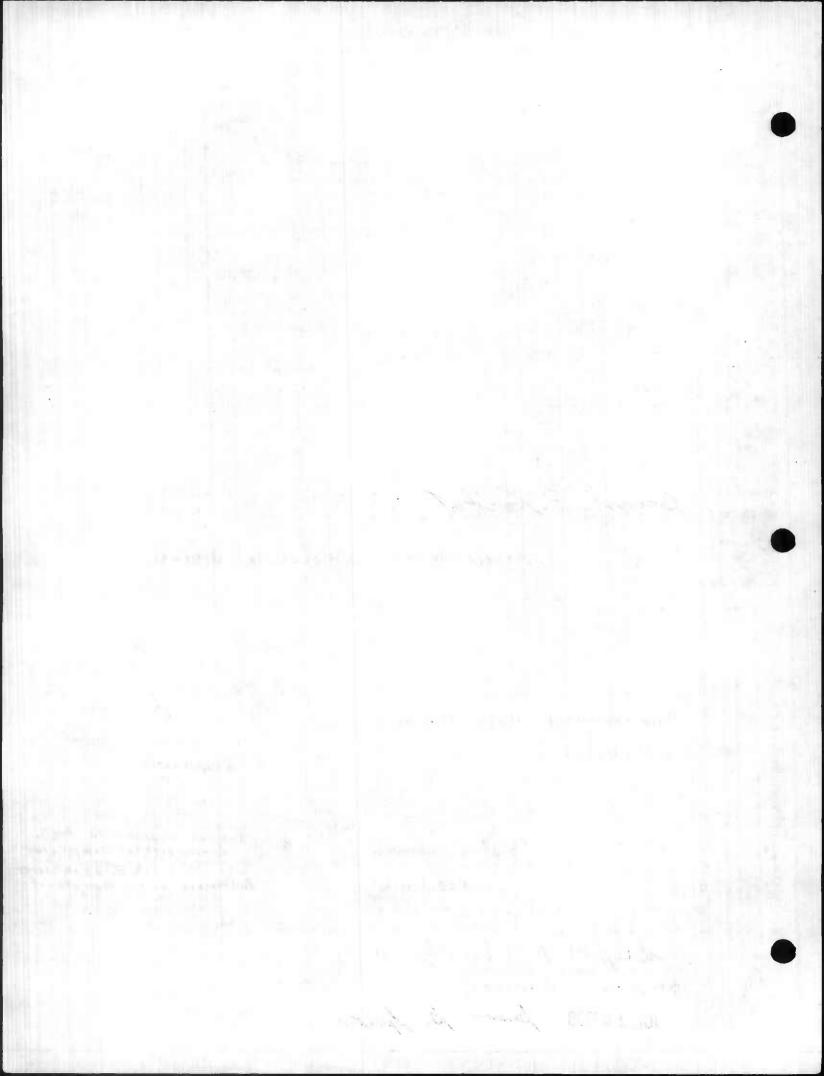
2 8 1999

Radentz 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signeture

Registrar

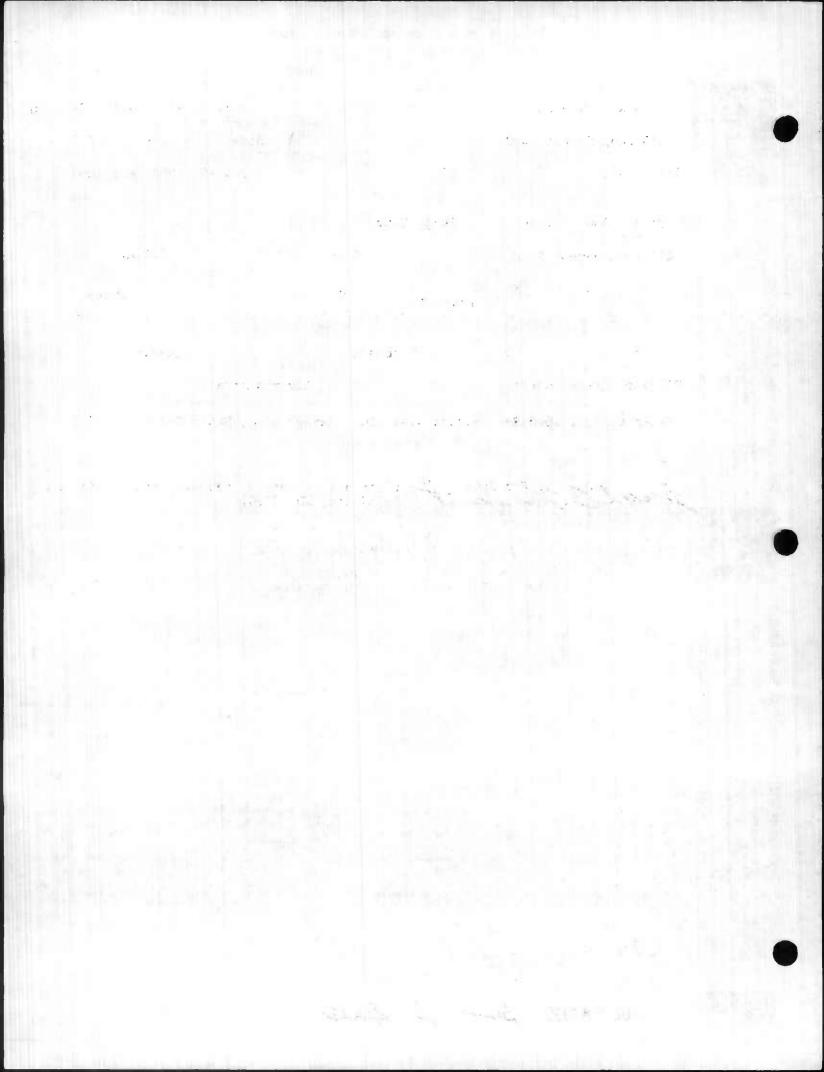
3 ☐ Suicide 4 ☐ Homicide

29e. Certifier (Check only one)



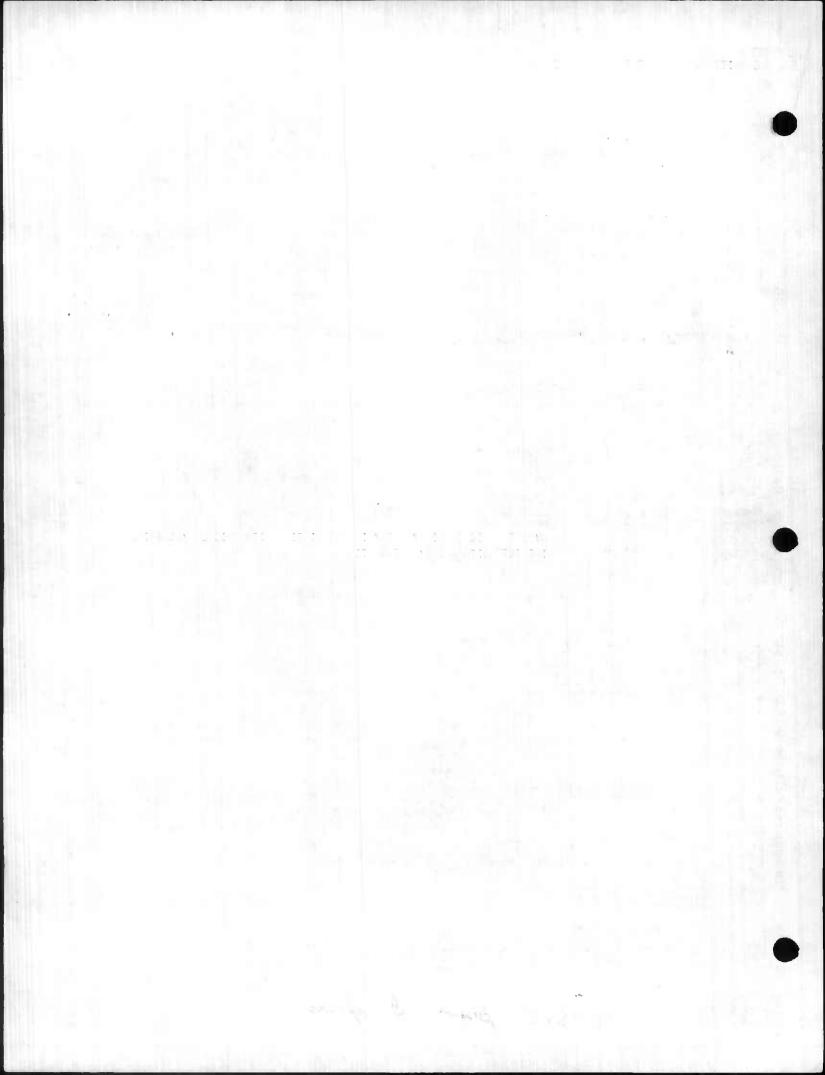
State of Maryland / Department of Health and Mental Hygiene 99 23737

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1	/Medica Examine		4a Facility Name (If not institution, give					4b. City, Town, or				o.so am
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	Funeral		5. Social Security Number 6. S		(In yrs. lest b		der 1 Year	If Under 24 Hrs	8. Dete of Birt	h		(State or Foreign
	Director .		214-14-5964 Usuel Residence of Decedent	2 M 2□ F	90	Yrs. Monti	hs Deys	Hours Min.	Fe. 25		Maryla:	
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	4.eh	ō	Maryland Anne Aru	1.1	Ch a lea	C4 1 -					,	1 ☐ Yes 2 ☑ No
	289 Pool	ec	Maryland Anne Aru	ndei	Snady	Side	Zip Code			10g. Citizen of V	Vhet Country?	
	With With	Funeral Director	1416 Sung Harbor	Road			20764			U.S.		
	Jeath Tre 2	era	11. Meritel Status	12. Wes Decedent 6	ver in U,S.			Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No		e - American fi	ndian,
21215-0020		by Fur	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ N If Yes, Give Yeer or Detes: 1			specify Cub s 2∭ No		to Ricen, etc.)		k, White, etc. white	
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g	office of Hyp	Be	17. Father's Neme (First, Middle, Last)					18. Mother's Ne	me (First, Middle,	Meiden Surnam	е)	
a	fenta fenta fred fred free	0	William Thomas Ro	gers				Alverta	Atwell			
Maryland	d 2 should th and Men 7 Is marke treumstic	-	19a. Informent's Name/Reletionship (7	Type, Pnint)	19	b. Meiling Addr	ess (Street	and Number or R	ural Route Numbe	er, City or Town,	State, Zip Coo	de)
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e,	of Heal Hem 2 other	1	20e. Method of Disposition			of Disposition (Name of		Dete	20c. Location -		
Baltimore,	00-		1 ☐ Buriat 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify)	Cerrien	ery, cremetory						
Bal	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licen	van Sahi	A	State	e Anat	ess of Facility Comy Boar MD 212		V. Balti	more S	treet
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-81	Physician		shock, or heert feilure. List only	one cease on eech iii	ю.							iset end Deeth
	/Medical	1	fmmediste Ceuse (Finel disease or condition	Aen	icato.	in (10)	Les	mone	3		61	130/99
	Examiner		resulting in deeth)	. Asp	Dua to (or on a	0.1	at):	01. 0	-		-	- / - /
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	ding ding	3		d								
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o.	the d	Physician/M	Pert II. Other significant conditions of	ontributing to death bu	it not resulting	In the underlyin	ng ceuse gi	ven in Pert i.		14		causs of death?
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u u	D 0 0	0	27. Manner of Death 1 Netural 5 □ Pending	28e. Dete of Injur (Month, De)	Year) 28b.	Time of Injury	28c. Inju Wo		28d. Describe	now injury occur	red	
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			30. Name and address of person who a	er 59 um		(Type, Print)	1501	11c Ro	d We	87 Ri.	Jer, m	n
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State of Maryland / Department of Health and Mental Hygiene Q Q 23738 JEFFREY RODDEN

AMENU 1	EM2:	#23 PARI 1, 2/ PER I	MEU G//4 8	-3-99 WR.	Cei	rtificate d	of E	Death			Reg. No.	6	3130
		1. Decedent's Nama (First, Middle,	Last)							2. Date of Do	eath Day	Year	3. Time of Death
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		GOOD SAMARITAN	HOSPITAL	L				BALTI	MOR	Ε		N/A	
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\$ 6 E	Sic	10e. Street and Number				10f. Zip Coo	de				10g. Citizen of \		
33 W	a	2202 Walshire	Avenue					2121	4		Unite	ed St	tates
1215-0020 within 72 hours after death with the Maryland and.	Funeral Director	11. Marital Statua	12. Was De Armed F	cedent Ever in U,S. Forces?	13.	Was Decedent If Yes, specify (of His	spanic Orig	gin? (Sp	ecify Yes or N Rican, etc.)	D- 14. Rac	can Indian, , etc.	
20 after	正	1 Never Married 2 Merrie	d 1 Tes	2 🖎 No		1 □ Yes 2 🖔		Specify:			Specify		White
21215-0020 d within 72 hours at giona. rr than *natural; or	d by	3 Widowed 4 Divorced	Year or	Dates:				_			WIII CC		
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1 and 1 Health om 27 I		Mrs. Dawn M. Rod	den (wi	fe)		Firet		rn Ro	ad		more, Ma		
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from	000	etery, crer	sition (Name o natory or other	place	9)	i	Date	20c. Location -	City or To	own, Stete
Baltimore, pemit. Pages 1 an Department of Heal Important: If tem 2 any Injury or other		4 Donation 5 Other (Spe	ecify)	Lake		Mem. (Gar	dens	į7	/31/99	Sykesv	ille	, Maryland
mit.	d	21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Fecility 5305 Harfo											rd Road
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To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		one)	and ma	nner stated.									
or or or	Σ												
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									JULY	27,	1999
Total Control													
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S	tate	31. Date filed (Month Day, Year)		Registrar's Signatur	0 6	. Sp	20 1	41					
Regis	trar	JUL 2	8 1999	Bereva	_	· popul	-						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middla, Last) 3. Time of Death 2. Deta of Death Month Dav **Physician** SHE ARIN 14158 DORO THY JULY 1999 صح /Medical 4a Famility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MORE If Under 1 Year 8. Dete of Birth Month, Day, Y. May 25, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) **Funeral** Days Min. 10 M 20 F Months 242 -52-1689 Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10d. inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28a-f show traumstic avant, the Medical Examiner must be notified all 12 Yas 2 No Director MORRE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Aith 212 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces?

1 Yas 2 No
If Yes, Give
Yaer or Dates: Bleck, White, etc. Peges 1 end 2 should be filed within 72 hours after 1 Never Merried 2 Married african 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify þ 3 ☐ Widowed 4 ☐ Divorced american Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grads completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 0016 Department of Health and Mental Hygis important: If Nem 27 is marked other is any injury or other traumatic avant, in page. 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be NO 0 llam 0 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Spoull 0 MO 2/2/8 More Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) husch 21. Signature of Funeral Sarvice Liceped alternice 402121 23a. Port1. Enter the disease, or complications that caused the death. Do not enter shock, or heart feilure. List only one cause on each line. the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Oriset and Death Physician /Medical immediate Cause (Final disease or condition resulting in death) Se PSIS Examiner Due to (or as a consequence of): Examiner scarci cular dy funch. and **burial-tran** Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Last Due to (or as a consequence of): physician WOUND'S ni c Physician/Medical the Dua to (or as a consequence of): 88 980 carcinoma detached Pert II. Other aignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yaa 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed peen s has certificate 1 Yes 20 No 1 Yas 2 No Attanding Physician: funeral director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Anpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Affer Netural DC 5 Pending death. 1 Yes 2 No investigation 2 Accident To the Hospital or Attand within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 4 THomicide 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to tha causa(s) and manner as stated. edical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 11390 NA 1999

State Registrar LOCH RAVEN BLUD

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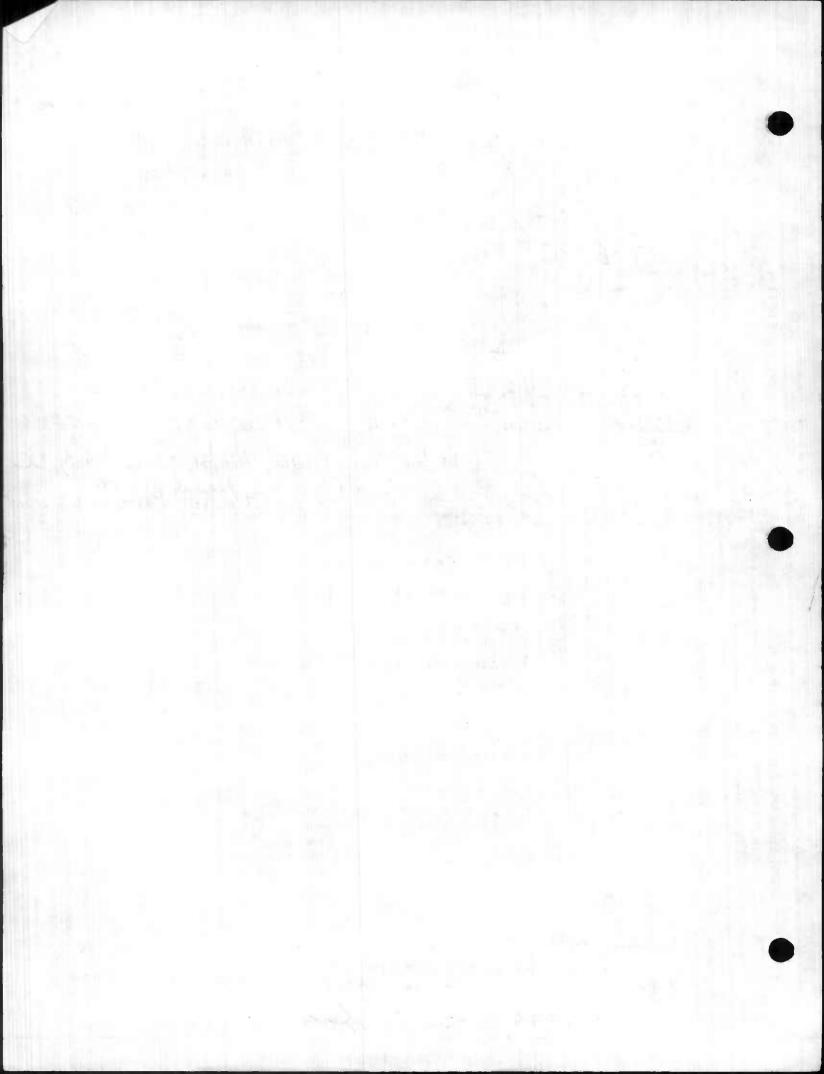
30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

SMBRA

31. Date filed (Month, Dey, Year)

5601

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dev Vest **Physician** JULY Catherine E. Sherry 8 1999 8:40 AM /Medical 4c. County of Death 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner CUMBERLAND MEMORIAL HOSPITAL ALLEGANY Hours Min. B. Dete of Birth (Month, Day, Year) Oct. 10,1908 If Under 1 Year 9. Birthplece (State or Foreign Country)
W. Va. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 TF 90 Yrs. Director 219-54-2066 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r than "natural", or flams 23s or 28s-f shor the Medical Examiner must be notified at 1 ☐ Yas 2 No Directo Maryland Allegany Cumberland 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21502 U.S.A. 11 Vermont Avenue Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important if flem 27 is marked other than any injury or other traumment. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. 1 ☐ Yes 2 1 No If Yas, Give Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 0 10 Housewife Own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Milo Henry Clem Pearl Everly 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 922 Weires Avenue, Lavale, MD John H. Sherry/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Joseph B. State Anatomy Board, 655 W. Baltimore Street a 21201 Baltimore, MD 23a. Pert1. Effer the disease, or complications that caused the deal shock, or heer teilure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Causa (Final a Hypertensive Arteriosclerotic Cardiovascular Disease > 10 years disease or condition resulting in death) Examine Due to (or as e consequence of) Examiner that the death certificate be assoured attending physician and for use as the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? O 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 0 Division of Vital Records. à The law requires 24b. Were autopsy findings available prior to Completed 24a. Wes en autopsy Deed completion of cause of death? hes TO Yes ZONo 1 ☐ Yes 2 ☐ No certificate Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred After 5 Panding investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident ofter death Director: 6 Could not be determined To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homloide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

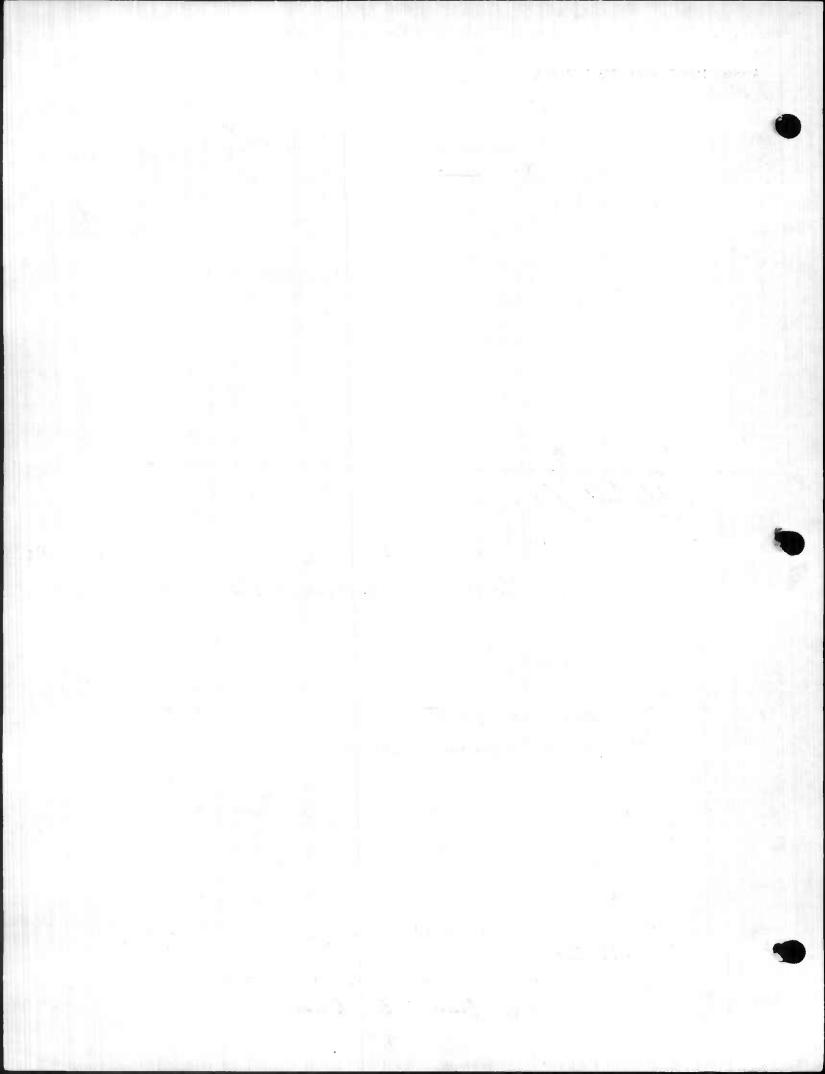
| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medicai minar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D16041 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) TERRY WILLIAMS, 500 MEMORIAL AVENUE, CUMBERLAND, MD 21502 32. Registrar's Signature 31. Date tiled (Month, Dey, Year) JUL 2 8 1999 Registrar

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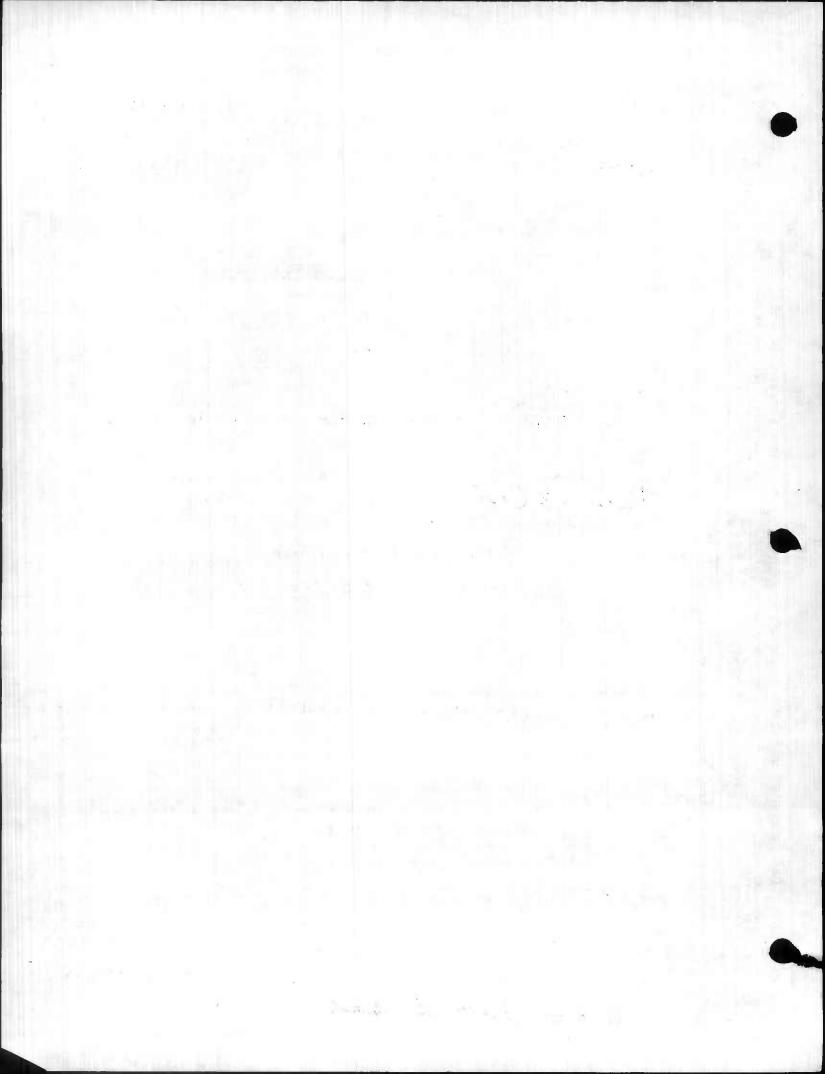
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Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) 4e. Facility Name (If not Institution, give street and number)	4b. City, Town, or I	2. Date of De Month 7 Location of Deat	Day Ye	19 12 00 Am
Funeral Director		Long Organ 115 E. Mollose Que 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs. Days Hours Min.	8. Date of Bir (Month, De Septembe	Ва	altimore City Birthpiace (State or Foreign Country) West Virginia
Marylend P-f ehow	tor	10e. Stete 10b. County 10c. City, Town or Location Maryland Baltimore County	Catonsville			10d. Inside City Limits 1 Yes 2 □ No
h with the 23a or 28s	Funeral Director	10e. Street end Number 1609 Park Grove Avenue	21228		10g. Citizen of Wha	t Country? U.S.A.
d 2 should be filed within 72 hours after death with the Marylend th end Mental Hygiene. 7 is marked other than "netural", or frems 28s or 28s-f show treumstic event, the Mexical Examiner must be notified at	by	11. Marital Status 12. Was Decedent Ever In U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Give 1 Yes, Give Year or Dates: 13. Was Decedent Ever In U.S. Armed Forces? 1 Yes, Give Year or Dates:	nt of Hispenic Orlgin? (Spy Cuban, Mexican, Puerto	pecify Yes or No o Rican, etc.)		American Indien, Vhite, etc. White
filed within 72 ho Hygiene. ther then "nature ent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collaga (1-4or 5+) 2	done during most of world	king	16b. Kind of Busine busin	ness college
should be filed and Mental Hygi marked other umetic event, t	To Be Co	17. Fether's Neme (First, Middle, Last) George Cromer	18. Mother's Nam		Maiden Sumame) arah Collins	
CTNL			Street and Number or Ru C Grove Avenue	Catonsville,	Maryland 212	28
Page nent c int: If ury or		1 Burial 2 □ Cremetion 3 Removal from Stata 4 □ Donation 5 □ Other (Specify) Cemetery, crematory or other Mountain View	er placa)	Date 07/26/99	20c. Location - City Marlintor	n, West Virginia
permit. Departr Imports any Inje		Optimilation State Moos35 Va	n Reenen Funera 7 9th Street Marli	inton, WV 2		Approximate
Physician /Medical Examiner		23. Part1. Enter the disease or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death)	inive	or roopilatory a	riost,	Interval Between Onset and Death
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The ate	Be Cor	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only o		1 Yes 2 No
iling Phys h. After this funeral di	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 X hursing H		dence 6 Other (S	Specify)
To the Hospital or Attent within 24 hours after deali To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 4 ☐ Homloida 28e. Place of Injury - At home, farm, street, fectory, obuilding, etc. (Specify)		City or To	vn, State)	r Rural Route Number,
the Hospital nin 24 hours the Funeral npletely filled	ledical	29a. Certifier (Check only one) Certifying Physician: To tha best of my knowledga, daath occurred at 2 Madical Examiner: On the basis of examination and/or investigation, in and manner stetad.	my opinion, daath occur	, and due to the rred at tha tima,	data and place, and	due to the cause(s)
To the within 2 To the comple	M	296. Signatore and title of certifier Medical Alterdati 29c. L	D171(8		29d. Date signed (M	onth, Day, Year)
		30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) Paul Schwaptzmp (15 E_Me(n))	e Ave z	1242		
Sta Registr		31. Date filed (Month, Day, Yaar) 32. Registra Signature 4.	book			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JULY **Physician** IFITIE 2-45 AM TODD 1997 24 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Liberty Medical Center Hours Min. 8. Date of Birth (Month, Day, Year) Aug 19, 1926 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplaca (State or Foreign Country)
N. Carolina **Funeral** Days 1□ M 25 F Months Hours 217-22-8045 72 Yrs. Director Usual Residence of Decedent the Maryland 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits than "netural; or items 23s or 28s-f show to Medical Examiner must be notified at 1 Yas 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4404 Kathland Avenue 21207 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 72 hours shar 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry oe filed within 7 ist Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Domestic permit. Pages 1 and 2 should be file Department of Hestih and Mentel Hy, Important: If them 27 is marked other eny injury or other treumatic event, pance. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) ? Meachum Eula Mae Hudson 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) West Todd (Husband) 4404 Kathland Avenue Baltimore, Maryland 21207 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet Cem 07/30/99 Owings Mills, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caple Funeral Service 21. Signature of Funeral Service Elcenses 5502 Winner Avenue Baltimore, Maryland 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximele Interval Batw Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical SEPSIS WITH Examiner DECUBITUS. Examine INFECTED physician and the burief-transit certificate be symcuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thal Initiated events resulting in death) Last Box 68760. Physician/Medicai Due to (or as a consequence of) 080 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? DEPENDENT DIABETTS MELLITUS 1 Yas 2 No 3 Probably 4 Unknown 6 Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 [Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 1No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 20 this After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. tnjury at Work? 28d. Describe how injury occurred or Attending To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 3 T Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Ber. Star so 2000 COBERTY HY AVE, BOILINGE, MD 21113 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REM SHAH M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 28 1999

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day William Month Physician 19 Fred 20noth ow 07 26 5230 BIM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 732 Charl Ford Bue B2/10, Maylor H Under 24 Hrs. 8. Date of Birth (Monthy Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1XM 2□ F 213-34-8740 60 Director Ma **Usual Residence of Decedent** the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mental Hygiene.
Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Madical Examiner must be notified at once. Baltimore 1 Xes 2 □ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. 4732 CHATFORD 21206 AVE. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 MYes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 Yes 28 No Specify: Specify: Black 2 If Yes, Give Year or Detes: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State division of Elementary/Secondary (0-12) College (1-4or 5+) Officers 121 orrectional Corrections 2/CARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 Williams Julius EHA Keely 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4732 ChatFord Balto. Williams AUE. SARAH MD. 2/206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Sleta 1 Burial 2 □ Cremetion 3 □ Removal from Stete GARTISON FOREST 8/3 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BeHs 1129 N. CARoline St. Baltimore, Maryland 21213 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Mindel /Medical Immediate Cause (Final Chrem burymine disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner Severe conditionyolatho attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): VRATIONAN TACKY (BIDIL Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yes 2 No ldypertersion Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No 25. Was cese referred to medical examiner?
1 Ves 2 No 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After if complately filled in by the funera 28c. Injury at Work? Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State DHMH 16 Ray 6/95

Registrar

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Larry 1.

31. Date filed (Month, Day, Year)
JUL 2 8 1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Genzynes

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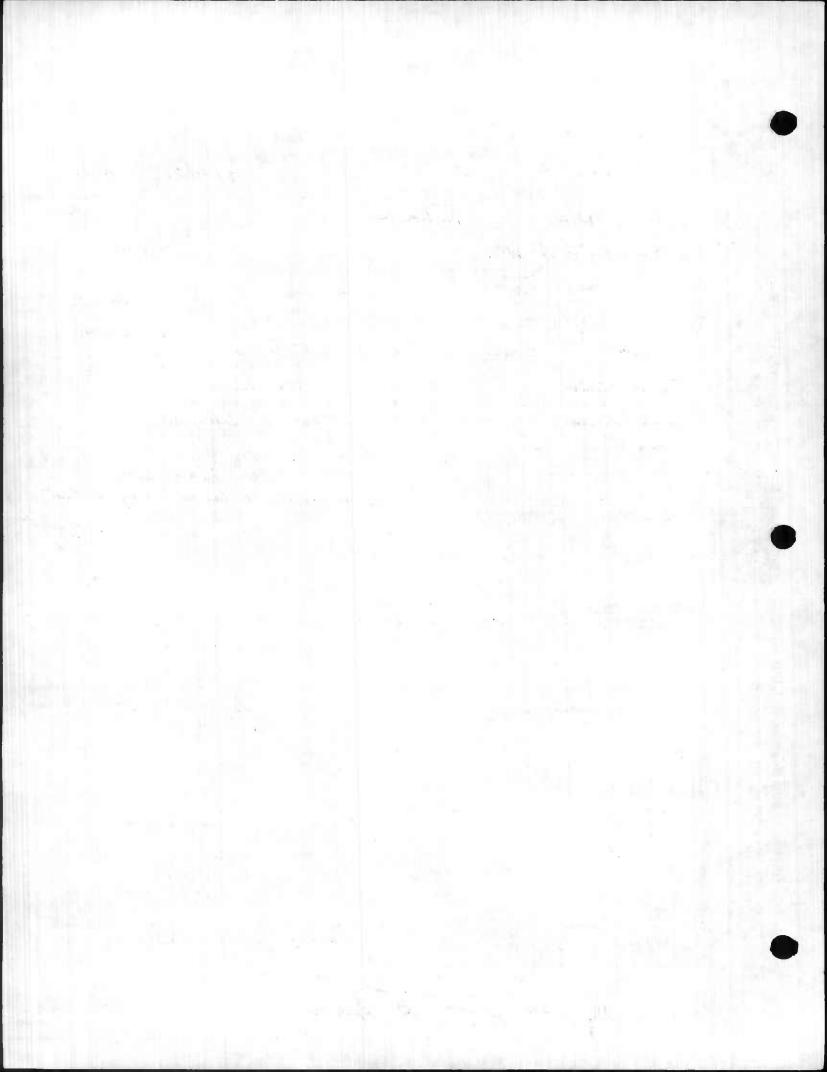
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32. Registrar's Signature

122131

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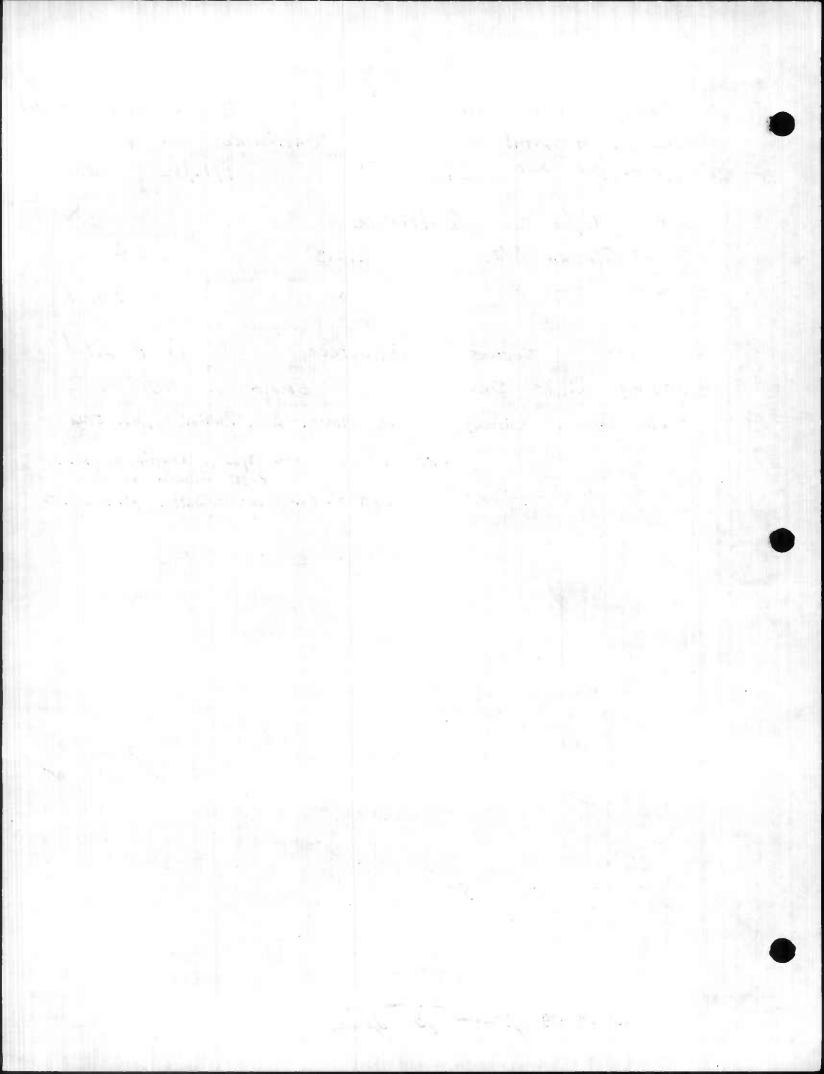
B2/70, rd 2/2/8



State of Maryland / Department of Health and Mental Hygiene 23744 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 5:40 AM Moxley /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3A/fimile
If Under 24 Hrs. 8. Dete of Birth
(Monty), Day, CHURCH HOSPITAL 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** 1X M 2 F Months 219-28-7958 16 Director 0 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itema 23a or 28a-f show treumetic event, the Medical Examinar must be notified at 1 Oces 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with U.S.A 3423 AVE 21213 MORA Funeral 4. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces?
1 (DYes 2 □ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status permit. Peges 1 and 2 should be filled within 72 hours effect Department of Heelth and Mentel Hygiene. Important: if Nem 27 is marked other than "natural", or Nem eny Injury or other treumatic event, the Medical Expenses 1 Never Merried 2 ☐ Merried BLAC Baitimore, Maryland 21215-0020 1 ☐ Yes 2 DXNo Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HO5 Volunteer SUEARS 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 8 Moxley SR. West. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore, MD. 21213 AVE. SAdie 3423 ELMORA Gooch (sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State on Forest Cem. 17/22/99
22. Name and Address of Facility Betts Fa BAHimore, MD. GARTISON 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Funeral Home N. CAroline St. Dalto., MD. 21213 1129 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** as Culas Theombosio /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ension physician and the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Records, P.O. Malletus Diabetee 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Demention pege 2 s 219 No 2010 1 🗆 Yes Division of Vital Hoopital or Attending Physicien:
 24 hours efter death.
 Funeral Director: After this certifical effect filled in by the funeral director. 25. Was case referred to medicat examiner? 8 26. Place of Death (Check only one) Hospital: 1 [Inpatient 1 Yes 2 LNC Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28h Time of 28c. Injury at Work? 1 National 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Cartifier 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ubelow 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) RD BALTOMDE (21) mD 4419 FALLS UBGROS 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State 1. JUL 28 1999 Registrar

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month :20 MM DEBORAH WILLIAMS 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) 4c. County of Death Battimere
If Under 24 Hrs. 8. Data of Birth
(Month) Day, Year) Manor Falls Care 5. Social Sacurity Number 217-18-9381 If Undar 1 Year Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Months Deys 1 □ M 20 F Yrs. 3-18-1920 VA. Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MD. MYes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3926 FERNHILL AVE. 21215 U.S.A. 14. Race - Amarican Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Bleck, White, etc. 1 ☐ Yas ZONo If Yas, Give Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: 3 Widowed 4 □ Divorced BLACK 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12 COOK ROSE WOOD STATE HOS. 17. Fathar's Nama (First, Middla, Last) 18. Mothar'a Nama (First, Middle, Maiden Surname) OERCY C. YOUNG BERTHA COLVIN 19e. Informent's Name/Ralationship (Type, Print) 19b. Malling Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) ELLEN SAMUEL 3926 FERNHILL AVE. BALTIMORE MARYLAND 21215 20b. Piece of Disposition (Nama of cemetary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata XX Burial 2 □ Crametion 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Othar (Specify) ARBUTUS MEMORAL PARK 7-28-99 BALTIMORE MARYLAND 21 Signature of Funeral Service Licenses 22. Nama and Addrass of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 er1. That the disaasa, or complications that cause of the deeth. Do not enter the moda of dying, such as cardiac or raspiratory arrest, hock, or haart failura. List only ona causa on account. Approximate Intarvai Between Onsat and Death CEREBRO VASCULAR THROMBOSIS Immedieta Ceusa (Finel disaasa or condition resulting in deeth) Due to (or as e consequence of) Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Diseese or Injury that initiated avents resulting in deeth) Last Due to (or es a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 Unknown m Elutus 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy YDROCEPHALUS t□Yes 2□No 1 ☐ Yes 2 ☐ NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Othar: ursing Home 5 Rasidence 8 Othar (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Natural 5 Pending

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/Medical

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Division of Vital or Attending after death. To the Hospital within 24 hours a To the Funeral D completely filled in

Registrar

State

VASNEEM 31. Dete filed (Month, Day, Year)

29b. Signature and titla of certifiar

2 Accidant

4 Homicide

3 Sulcide

29a. Cartifiar

7220

29c. License number 28591

Cartifying Physician: To the best of my knowledga, death occurred at tha tima, data and placa, and dua to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Deta signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

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Investigation

6 Could not be datarmined

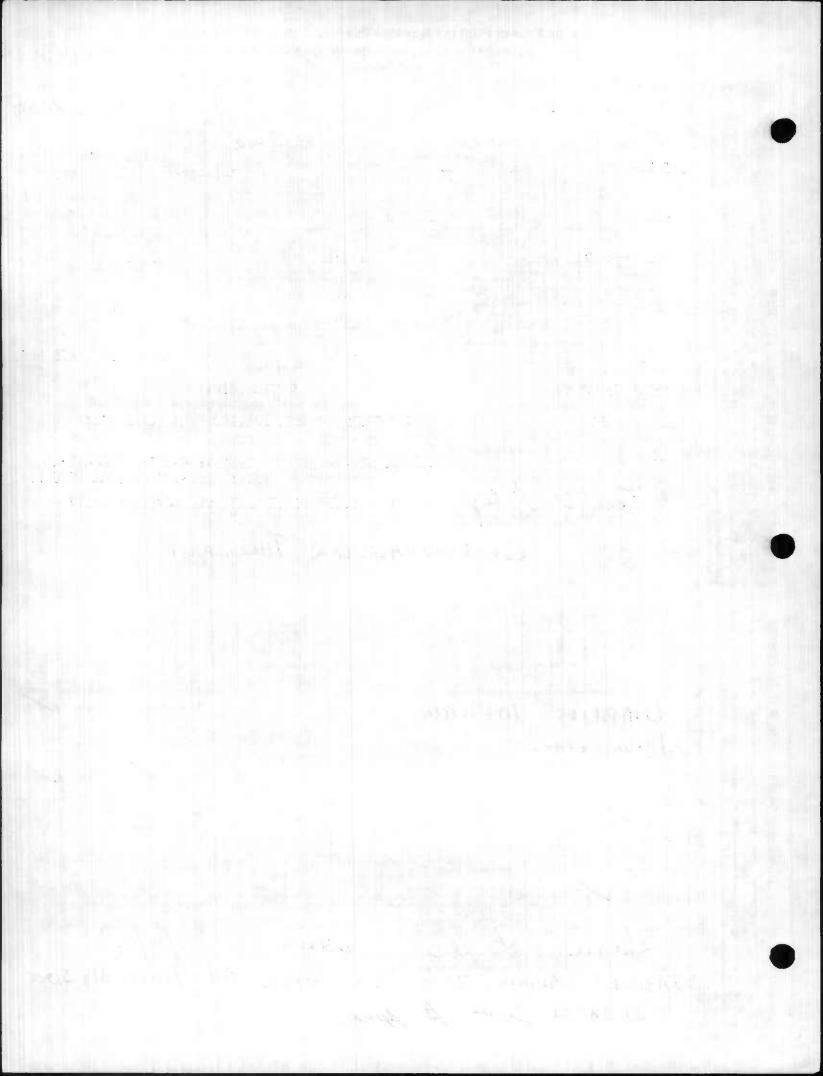
HEIGHTS AVE BALTO MD 21308

1 Yes 2 No

30. Nama and addrass of person who complated causa of death (itam 23a) (Typen Print)

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

32. Registrar's Signature JUL 28 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death om THOMAS A. WHITBY JR. ILL 4e Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of seltimore City rapyland General If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7 - 9 - 1966 If Under 1 Yeer Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Days Months 100M 20 F 212-86-7390 33 MD Usual Reaidence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inalde City Limits MD. BALTIMORE 1X Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5098 CLIFTON AVE. 21207 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1/ X/ves 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus 1 ☐ Never Married XX Married 1 ☐ Yes 2XXVo Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER SWIFT TRANSPOTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THOMAS A. WHITBY SR. LORETIA NIXON 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NECOLE WHITBY 5098 CLIFTON AVE BALTIMORE MARYLAND 21207 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XS Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 7-27-99 BALTIMORE MARYLAND 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 Approximete Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that in the lead of the cause (Disease or Injury that in the cause of the cause (Disease or Injury that in the cause of the cause o 5 Due to (or as a consequenca of): resulting in death) Last Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Type 2 No 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 (D) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Mannaf of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Descripting Phyeicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier (Check only

of Vital Division or Attend efter death Director: / To the Hospital within 24 hours e To the Funeral D

Registrar

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Funeral

Director

If is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

Mentel

Department of Health e Important: If Item 27 is any Injury or other train once.

Physician

/Medical Examiner

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30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

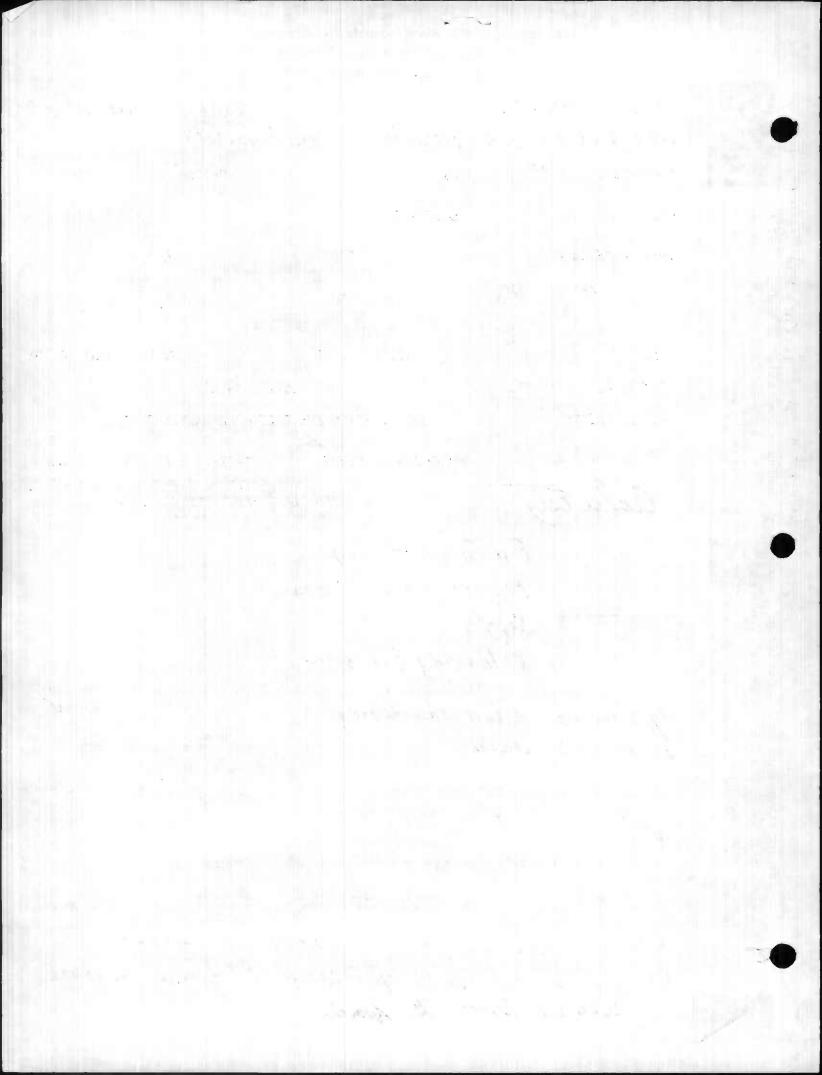
Maryam Saumai, m.D. Co

29b. Signature end title of certifier

36. Registrar's Signeture

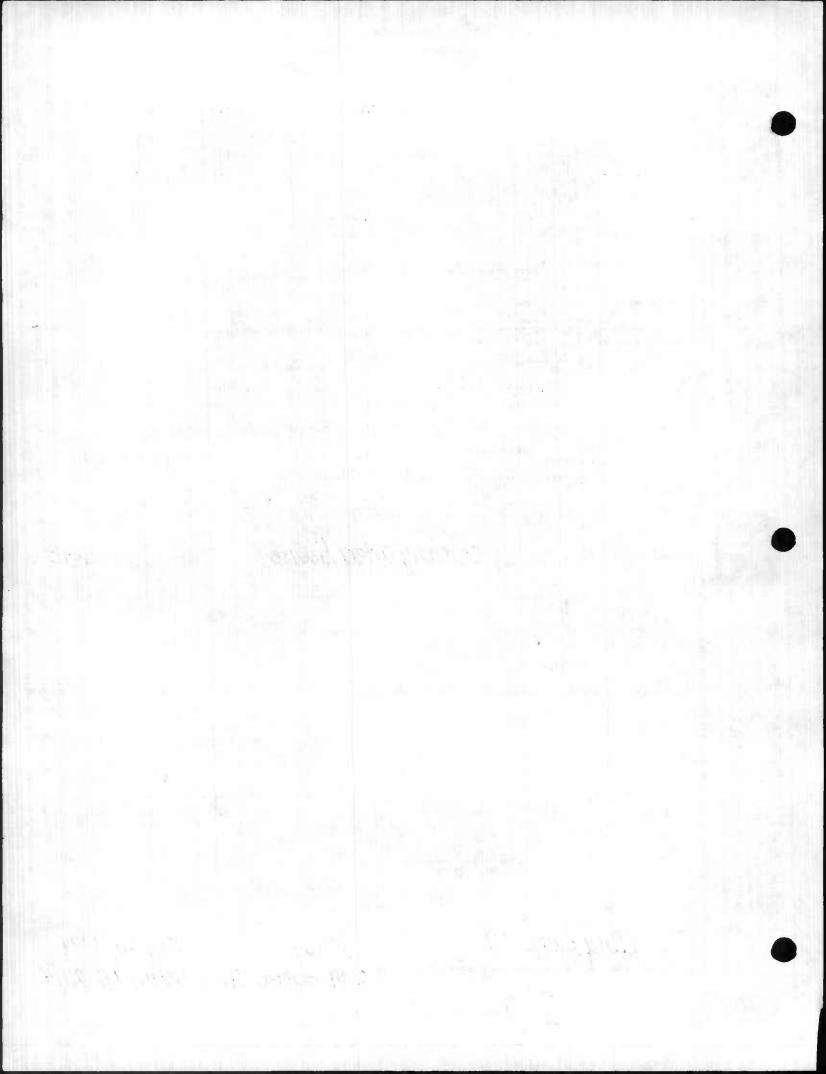
Maryland Greneral Hospital

29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Q Q 271.7

Physician /Medical Examiner					C	ertificate	e of	Death		F	Reg. No.		.0141				
/Medical Examiner	1. Decedent's Name (First, Midd	lle, Last)					0.4		1	2. Data of Dea Month		Year	3. Tima of Death				
Examiner			Will	liam (G. W:	ilhelm				July 2	3.1999		10:00P.M				
	4a Facility Nama (If not institutio	n, give si					- 1	4b. City, Town			-	nty of Death					
	112 Fourth	Ave.						Balt	imor	e	Anne	Arun	del Co.				
61	5. Social Security Number	6. Sex	7	Age (In yrs.	last birthda			If Under 24			10000		place (State or Foreign				
	214-01-5788	150	M 2 F	86	Yrs.	Months	Days	Hours	Min.	Data of Birth (Month, Day NOV • 29	.1912	Mary	land				
	Usual Residence of Decedent																
	10a. Stata 10b. County				y, Town or	Location							10d. Inside City Limits				
o	Maryland Anne	Arun	del Co.		E	Baltim	ore						1 ☐ Yas 2 ☐ No				
9	10e. Street and Number					10f. Zip	Code				10g. Citizen o	f What Cou	intry?				
	112 Fourth	7					212	25			U.S.	70					
Funeral Director	11. Marital Status		2. Was Deced	ent Ever in U	.S. 13	3. Was Deced	-		n? (Spec	ity Yes or No-	The second secon		ican Indian.				
5	1 Never Married 2 Mar		Armed Force	es?		If Yas, spec	cify Cuba	lispanic Origir an, Maxican, I	Puarto Ri	ican, atc.)	В	lack, Whita	, atc.				
Š	3 ☐ Widowed 4 ☐ Divorced		If Yes, Give Year or Date			1 Yas	2 No	Specify:			Spec	ity: Wh	ite				
	15. Deceder	nt's Educ			16a. Dec	cedent's Usua	al Occup	ation			16b. Kind of	Businass/li	ndustry				
	(Specify only highe	est grade	completed)		(Gir	ve kind of wor . DO NOT us	rk done	during most o	f working	7			,				
Be Completed	Elementary/Secondary (0-12)		College (1~	or 5+)				thogra			CS	v					
5	17. Father's Nama (First, Middle,	Last)	IV/A		1 1	VECTIC	Y 111			First, Middle,							
á		arry	Wilhe	elm,Sr							O'Mear						
2	19a. Informant's Name/Relations			,		- معامله ومثاث	/Com						in Codel				
				11.6				and Number					p 5000)				
	A. Isabelle W. 20a. Method of Disposition	11he	TW A	vife		Fourt		e.Balt	1mor	e,Mary	Land 2		our State				
	1 ☑ Burial 2 ☐ Cremation	3 □Re	moval from St		semetery c	rematory or o	ther niar	ce)	1 27			-	aryland				
	4 Donation 5 Other (S				uai n.	III Cei	mete	ry our	YZI	, 1999	Daltin	ore, M	aryrand				
	21. Signature of Funeral Service	Licensee	Kevin	E. Ec	ker .	22. Nama an	d Addra	ss of Fecility	Thus	con l	iomo D	70					
-	237 E. Patapsco Ave. Baltimore Maryland 21225																
7	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Betwee																
	shock, or heart lailure. List	t only one	ceuse on eac	th line.								į	Onset and Death				
	Immediata Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												11000				
	disease or condition resulting in death)	a.		VOIO	nuig	arre	y a	126776	2			1	gegs				
6				Due to (d	or as a co ns	sequence of):(V					İ	U				
edical Examiner	b.																
Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			D00 10 (c	n as a cons	equence or):											
9	Cause (Disease or injury that initiated events	C.		Due to le		equence of):											
8	resulting in death) Last			000 10 (0	ras a cons	equence or):											
3	d																
Sel																	
YS	Part II. Other significant condition	ons contr	ributing to deal	h but not res	ulting in the	underlying ca	ausa giv	ren in Part I.		23b. Did 1	obacco use o	contributa	to the cause of death?				
Physician/M										101	708 2□ No	3 □ Pr	obably 4 Unknow				
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Completed									_		1	1 0	ompletion of cause f death?				
5										101	as 21 No	1	□Yes 22 No				
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2	25. Was pase referred to medical an applifiner? 1 12 Yes 2 No																
10 26	1 ☑ Yes 2 ☐ No 27. Manger of Death																
To Be	1 Ves 2 No 27. Manuer of Death 1 Natural 5 Pendir		1 12 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No														
	1 12 Yes 2 No 27. Manner of Death 1 12 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	not be	28e Place of	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, street, factory, office 28f. Location (Street and Number or R													
000	1 12 Yes 2 No 27. Manyrer of Death 1 12 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	not be	28e. Place of building	Injury - At he etc. (Specif	determined 288 Place of Intuity - At nome farm street factory office 201. Location (Street and Pointer of Pointer Pointer Pointer Pointer)												
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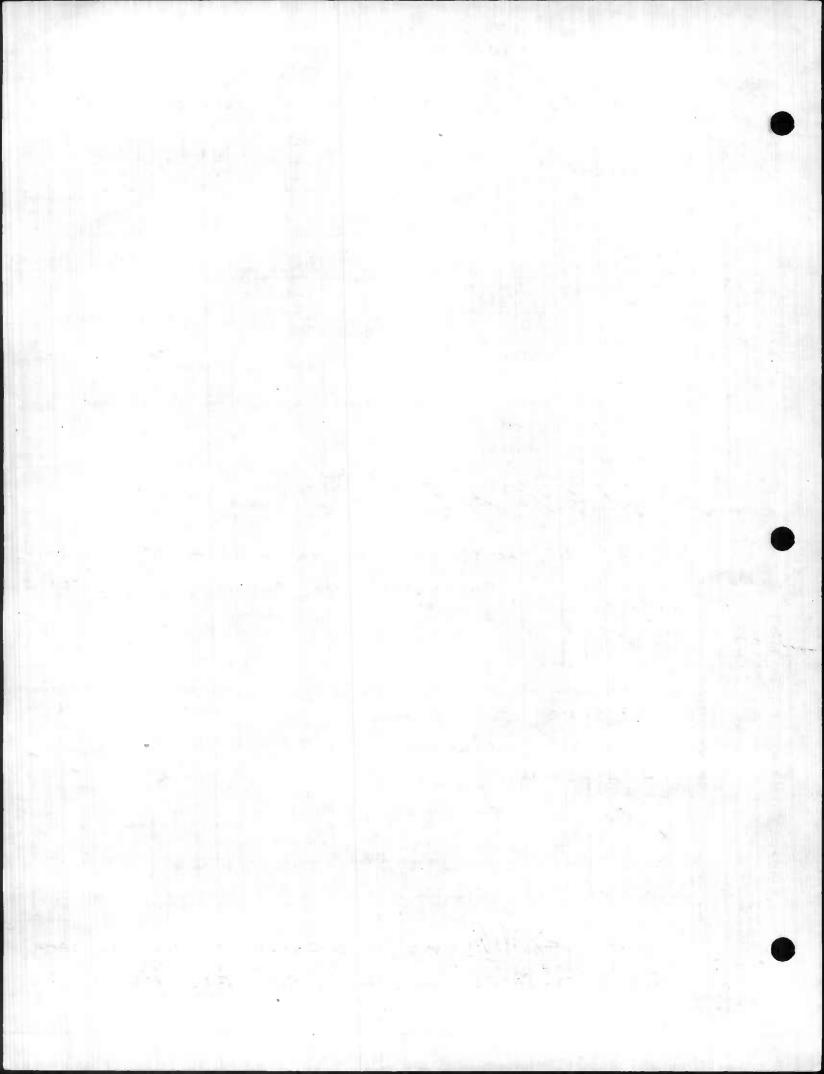


AMEND	#5 PER ADMIN	ι Δ SST G			ind / Dep <i>Ce</i>	artment o <i>rtificate</i>	of De	alth and N eath	Mental Hy	rgiene 9	9 2	23748	
Physicia	1. Decedent's Na		Last)	2 U.A.					2. Date of D Month JUNE	eath Dey	999 Yeer	3. Time of Death 1115 AM	
/Medica Examine	4a Facility Name		give street and n	umber) STREET	APARIMI	ENT 8F	4b. 0 B	city, Town, or L ALTIMOR	ocation of Dea E	th 4c. Co	unty of Deat	th	
Funeral Director	5. Social Security 2117 2717-40-2	995	3. Sex 1 Ø M 2 ☐ F	7. Age (In yr.	s. lest birthday, 3 Yrs.	Months D		Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, D April	rth ay, Year) 3,1956	9. Bird Co unkn	thplace (State or Foreig ountry) OWN	
pu k m	Usual Residence	10b, County		10c. (City, Town or L	ocation						10d. Inside City Limit	
Mary	Maryland			B	altimor	· e						tX Yes 2 N	
r 28e	Maryland 10e. Street and No				ar crimor	10f. Zip Co	de			10g. Citizen	of What Co	ountry?	
th wif	401 E. 2	5th Stre	et, Apt.	8F		21:	218			U.	S.A.		
1.2.13-UUZU within 72 hours efter death with the Maryland ane. then "natural", or flams 23e or 28e-f show he Madical Essentias must be notified at	11. Marital Status 1 Never Mar 3 Widowed	rried 2 Marrie	12. Wes De Armed F	cedent Ever in Forces? 22 No Sive	U,S. 13.	Was Decedent If Yes, apecity 1 ☐ Yes 20		inic Origin? (Sp Mexican, Puerto pecify:	pecify Yes or N Rican, etc.)		Bleck, Whit	orican Indian, a, etc. hite	
Maryland 21215-0020 d 2 should be filed within 72 hours et ith end Mentel Hygiene. 77 ie marked other than "natural", or treumatic event, ins Medical Essen	Elementary/Sec	15. Decedent's scify only highest condary (0-12)	grade completed College	(1-4or 5+)	(Give	dent'a Usuel O a kind of work of DO NOT use r	lone durir etired)	n ng most of work	king		of Business	Andustry	
e filed v i Hygie other ti	unknown 17. Father's Name	/Firet Middle 1	unknown		Tele	market:	9	Mother's Nem	ne (First, Middle	unkr			
Ne, Maryland 212 1 and 2 should be filed withir fileatith and Mentel Hygiene. from 27 is marked other tran other treumatic event, the Hy	Ď .		· ·						Sciesz		nomey		
2 should by end Ments le marked eumatic ex	-	Name/Relationshi			19b. Meil	ing Address (S	_		ral Route Numi		wn, Stete,	Zip Code)	
	Sandra	Cox/daug	hter		unkno	wn							
Dallimore, Namit. Pages 1 end Department of Health Mportant: If New 27 Bry Injury or other ta	20a. Method of Di 1 Burial 2		B □Removal from	n State	Place of Disp cemetery, cre	osition (Name on attention of the matory or other	of r place)	1	Date	20c. Locati	ion - City or	Town, Stata	
pamit. Pages Department of Important: if it eny injury or once.	21. Signature of F	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore, MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
Physician /Medical Examiner	Immediate Causa disease or conditi resulting in death	ion	. At	Horosco Due to	Knark (or as a conse		1) 101	MSchir	n Dis	CDSE.		3,	
Micate be associted ficate be associted a physicien and as the burial-transit	Sequentially list of if any, leading to cause. Enter the Cause (Disease of that initiated even resulting in death)	erinjury ts	c		(or as a conse							2.	
0 4 64 .			d		<u>-</u>	_							
deeth certifi	5								1 5				
d by th	Part II. Other aign	ificant condition	s contributing to	death but not re	esulting in the u	inderlying caus	e given i	n Pert I.		Yaa 2 l		to the cause of death robably 4 Unknow	
he law requires the hes been signed 20 2 should be									24a. We per	s an autopsy omed?	24b.	Were autopsy lindings available prior to completion of cause of death?	
F 22	5								10	Yes 2 N	lo	1 Yes 2 No	
ysician: The	25. Waa case refe axaminer?	erred to medical	11					3. Place of Dee	th (Check only	one)			
a the o	27. Manner of Dec		28a. Date (Mo		28b. Time of Injury		Injury at Work?	4 Nursing H	ome 5 Res 28d. Deacribe			ocity)	
or Attending as effective. After death. I Director: After delin by the fune	27. Manner of Dec 1 Natural 2 Accident 3 Suicide 4 Homicide	6 Could no determin	ed 288. Plac	se of Injury - At ding, etc. (Spec	home, ferm, st	reet, factory, or	ffice			(Street and Nown, Stete)	umber or R	ural Route Number,	
he Hospi in 24 hou he Funer pletsly fil	29a. Certifier (Check only one)		Physician: To the saminer: On the and ma			westigation, in	my opini	on, deeth occu		, date and pla	ice, and du	e to the cause(s)	
To with	29b. Signature as	lloupet	e Oh	elh	ele in	M	O.C.			29d. Date s JUNI	igned (Moni E 25,	th, Day, Year) 1999	
Gr.	30. Name and add	1sart	no completed cau	Fw 11	1 Penn	Street	, Ba	ltimore	, Mary	land 2	1201	4 3	
State Registra	31. Date filed (Mo	2 8 1999		Registrar's Sign	A	100							

JUL 2 8 1939 July 1960 8 8 JUL

State of Maryland / Department of Health and Mental Hygiene 0 0 2271, 0

				C	ertificate d	of Death	R	eg. No.) 6	0/49					
	Dhambalan	1. Decedent's Neme (First, Middle, Last)				2. Dete of Deal Month		Year	3. Time of Dea	-				
	Physician /Medical	HENRY			WAT	SON	JK2Y	02 1	999	12:40	9				
	Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death						
		Liberty Medical C	enter	0		Baltimo	ore								
-	Funeral	5. Social Security Number 6. Se		rs. last birthd	Months Da	ear If Under 24 Hrs	8. Date of Birth	Voorl	9. Birthple	ace (Stele or For	reign				
	Director	220-38-6061	ØM 2□F	87 Yrs	Months Da	ys Hours Mill.	Jan. 27	, 1912	Mary	land					
	Du .	Uaual Residence of Decedent 10a, Stete 10b, County	100	City, Town or	r Location				140	od Insida Cit. I i	lan lan				
	aryla ahon der		100.	City, Town or	Location				10	od. Inside City Lin ty⊡ Yes 2 □					
	Ne M	MD	E	altimo			,				1140				
	or 28s-falls northed	10e. Street and Number			10f. Zip Cod	le	1	0g. Citizen of W	Vhat Count	ry?					
	23a 23a	2507 Elsinore Aven	ue		21216			U.S.	A.						
	free death with the Marylar r thems 23s or 23s-f show the prest to mortified at Funeral Director	11. Maritei Stetus	12. Wea Decedent Ever in Armed Forces?	U,S. 1	Wes Decedent If Yes, specify 0	of Hispanic Origin? (S Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)		e - America k, White, e						
21215-0020	by F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 ☐ Yea 2 ☑ No If Yes, Give Yeer or Detes:		1 ☐ Yes 2 🔯			Specify							
20	ed within 72 hours yglene. er than "natural", t, the Medical Earl Completed by	15. Decedent's Edu (Specify only highest grad		16a. De	ecedent's Usuel Oc	cupetion	dina	16b. Kind of Bu	siness/Ind	ustry					
2	within the transfer of the tra	Elementary/Secondery (0-12)	College (1-4or 5+)	life	e. DO NOT use re	ne during most of wo tired)	rking								
	D 2		nknown	Non	ne			None							
Pu	进生后 9 1	17. Father's Neme (First, Middle, Last)				18. Mother's Ne	me (First, Middle, I	Maiden Sumem	Θ)						
Maryland	2 should be and Mentai I is marked of reumatic ave	unknown				unknow	m .								
lan	2 sho	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. M	alling Address (Str	eet and Number or R	ural Route Number	, City or Town,	State, Zip	Code)					
	1 and 2 Health am 27 i	Ellwood Beale/ca	retaker	250	3 Elsino	re Avenue,	Baltimo	re, MD	2121	.6					
ore	200	20a. Method of Disposition 1 Burial 2 Cremation 3 DF			sposition (Name o		Date	20c. Location -	City or Tov	vn, State					
E	Pages nent of I int: If its	4 □ Donation 5 ☑ Other (Specify)													
Baltimore,	permit. Page Department of Important: If any Injury of any Injury of any Injury of	21. Signature of Funeral Service Licens		1	22. Name and Ad										
m	88 E E 8	Joseph B. Jan Sant State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201													
		23a. Part 1. Piter the disease, or compl	icetions thet caused the de					est,	- 1	Approximate					
	Physician	snock, or neer failure. List only of	ne ceuse on each line.						1	triterval Between Onset and Deatl	h				
	/Medical	Onset and Do													
	Examiner	resulting in deeth)	Due to	(or as a con	sequence of):	VASCIC	C/FI /1			8 DAY					
	ē		Palui	Man	111. 24	HA SE	Pais			7 DAY	15				
	ificate be executed g physician and as the burial-transit	Sequentially tist conditions.	Due to	(or as a con	sequence of):	70. 3-	/3/3	-							
Ó	Ex man	Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury							i						
68760,	icate be physicial s the bu	that initieted events resulting in death) Last	Due to	(or as a con:	sequence of):										
	E 00 E	resulting in death) cast													
Box	attendir for use		1						1						
	at the death cent by the attendinets by the attendinets by the attendinets by the standard by the sician/W	Pert II. Other significant conditions cor	ntributing to death but not i	esulting in th	e underlying cause	given in Pert I.	23b. Did to	bacco use cor	ntributa to	the cause of de	with?				
P.0	by the tach		4				1 D Y	es 2 No	3 Prob	ably 4 Unk	nown				
	ope de de de de de de de de de de de de de	- SEIZUKE	D150X	DEX	5 '										
of Vital Records,	v requires that the death cer been signed by the attendir should be detached for use leted by Physician/A	- SEIZURE - RENAL	EANI	DE			24a. Was a perform	n autopsy		re autopsy findin	ngs				
000		NENA L	FAILL	1 FL	-				CON	npletion of cause leath?	•				
Æ	The law ata has b page 2 s	- ANAEM	IA				1 U Y	es M No	10	Yas 2□ No					
tal	sician: The law certificata has t lirector, page 2 s o Be Compil	25. Wes case referred to medical	7-7			26. Place of De	eth (Check only or								
>	Physician: this certific ral director.	axaminer? 1 ☐ Yes 2,00 No	lospitel:	☐ ER/Outpa	tient 3 DOA	Other	Home 5 ☐ Reside		er (Specify)					
0	eral o	27. Menner of Death	28a. Date of Injury (Month, Day Year,	28b. Time		njury at Work?	28d. Describe h	ow injury occurr	ed						
0	leath. for: After th the funeral cation:	1 Netural 5 Pending investigation	(MOHIII, Day Year,	Injui	,	Yes 2 No				\					
Division	tal or Attanding P rs after death. at Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Plece of Injury - A		, street, fectory, off	ce	28f. Location (S. City or Town	treet and Numb	er or Rural	Route Number,					
ä	d in d	4 Homicide	building, etc. (Spe	спуј			City or Yow	i, Siate)							
	noun hours hours y fille		sician: To the best of my k												
	ne Hoepl n 24 hound ne Funer pletely fit edical	(Check only 2 Medicat Examinations)	ner: On the basis of exam and menner steted.	inetion and/or	r investigetion, in r	ny opinion, deeth occi	urred at the time, d	ate and place, a	and due to	the cause(s)					
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by it Medical Certific	29b. Signeture and title of certifier	nd n		29c. Lic	ense number	2	9d. Date signed	d (Month, E	Day, Year)					
		1 L	SWINS	ומים.		23300	,	JULY	02	1990	7				
		30. Neme and address of person who co	impleted cause of death (f	tem 23a) (Tvi	pe, Print)	liberty.	hodin	£ 100	V7.	. , ,	1				
	CA	SUDMIR. D.		260	o Liles	ibesty. ty Rdi	BAZ	. 100	2	21215					
	State	31. Date filed (Month, Day, Year)	22. Registrer's Sig	nature	1	1	7,								
	5-1-1-1	IIII 0 2 1000	newa	14	1										



State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

		Certificate of Death	Reg. No.	
1. Decedent'a Neme (First, Middl	e, Last)		2. Date of Death	3. Time of Death
nysician Tourses	1 116:40	T	Month Day	Year 0228 AM
Medical	7. 00116	th City Town	or Location of Death 4c. County	99
miner 4a Facility Name (If not Institution				or Death
1704 MOSHER S	IREEI	BALTIM	DRE	11/A
5. Social Security Number	6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 H Months Days Hours M		9. Birthplace (State or Foreign
246-44-1699	12M 2DF 6.5	Yrs. Months Days Hours M	11/20/33	Vanto Caroli
Usual Residence of Decedent			11/0//	VOI TIT COILON
10a. State 10b. County	10c. City, To	own or Location		10d. Inside City Limits
5 111	114 120	111		12 Yes 2□No
	101	1710016	To be a	7,7 55
10e. Street and Number	11	10f. Zip Code	10g. Citizen of W	mat Country?
1104 Mosh	er 5t.	2/2/7	43	4
10e. Street and Number 1764 Mo5ht 11. Meritat Statua 1 Never Merried 2 Man	12. Was Decedent Ever in U,S.	13. Was Decedent of Hispanic Origin?		- American Indian,
1 Never Merried 2 Man	Armed Forces? 1 Yes '2 DNo If Yes, Give	If Yes, specify Cuban, Mexican, Pu	ento rican, etc.) Blect	k, White, etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	1 Yes 2 No Specify:	Specify:	Black
	102 0. 2200.	S. D. de Maria Maria Maria	40h Wind of Bu	10/0/0/1
(Specify only highe	t's Education 10 st grade completed)	6a. Decedent's Usuel Occupation (Give kind of work done during most of v	vorking 16b. Kind of Bu	ainess/industry
Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		1 . /
S ±A	NIA	Laborer	(,005	struction
17. Father's Neme (First, Middle,	Last)	18. Mother's N	lame (First, Middle, Maifen Surname	9)
Trumps	116:40 50	Evol	Um. 116 40	
19a Informant's Name (Palations	hip Gross Grintly Co.)	Ob Mailing Address (Street and Alumber of	Provide Marchael Gibbs Town	Otate Zin Cada)
19a. Informant's Name/Relations	hip (Type, Print) frigig 1	9b. Meiling Address (Street and Number or	Hurai House Number, City or Town,	State, Zip Cooe)
Lacqueline	Heming 1	704 Mosher 5t. 1	saltimore, 41	12/2/7
20a. Method of Disposition	0000	of Disposition (Name of otery, crematory or other place)	Date 20c. Cocation -	City or Town, State
1 ABurial 2 Cremation 4 Donation 5 Other (S	3 Li Hemovai from State	Z'an Complant	7/08/00 1	Louis uh
21. Signature of Funeral Service		22. Name and Address of Facility	1100177 241170	TOWNE FIL
21. Signature of Furieral Service	Dicerisee	22. Name and Address of Facility	Mett P. Wylie	1-11, P.M.
		625(1) 6ilman	A Baltimar	P 41) 2/2/
23. Part . Enter the disease, or	complications hat caused the deeth. D	On not enter the mode of dying, such as card	fiac or respiratory arrest,	Approximate
shock, or heart feilure. List	only one cause on each line.			Interval Between Onset and Deeth
Immediate Cause (Final				
disease or condition resulting in death)	. Hypertensive	Arteriosclerotic Car	diovascular Dise	ase
370	Due to (or as	a consequence of):		
Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying				
Sequentially tist conditions.	Due to (or as	a consequence of):		
Sequentially tist conditiona, if any, leading to immediate cause. Enter Underlying				
cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C			
resulting in death) Last	Due to (or as	a consequence of):		
	4			
Part II. Other significant condition	W.			1
Part II. Other significant condition	ns contributing to death but not resulting	g in the underlying cause given in Part t.	23b. Did tobacco use con	tribute to the cause of death?
				3 Probably 4 Unknow
			_ 10100	- apondow
				0.45 341 4 (1-4
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to
			- Spection	completion of cause of death?
			1 TYes 2 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medica examiner?		26. Place of E	Death (Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Other: 4 Nursing	g Home 5 ☐ Residence 6 KM the	or (Specify) SCENE
27. Manner of Death		b. Time of 28c. Injury at	28d. Describe how injury occurre	
1 Metural 5 ☐ Pendir 2 ☐ Accident investi		tnjury Work? M 1 Yes 2 No		
3 Suicide 6 Could	not be		COM A continu (Count and Abunda	er en Direct David Markey
4 Homicide determ		, term, street, factory, office	281. Location (Street and Number City or Town, State)	er or Hurai Houte Number,
27. Manner of Death 1 Metural 5 Pendir 2 Accident investi 3 Suicide 6 Could determ 29e. Certifier 1 Certifyin		ige, deeth occurred at the time, date and pla		
29e. Certifier 1 Certifyin (Check only one) Medical	Examiner: On the basis of examinetion and manner steted.	and/or investigation, in my opinion, deeth oc	ccurred at the time, date and place, a	and due to the cause(s)
29b. Signature and title of certifie		29c. License number	29d Date signed	(Month, Day, Year)
29b. Signature and title of certifie		Evo. Evolido Harrisal	200. Date arginee	(

State Registrar

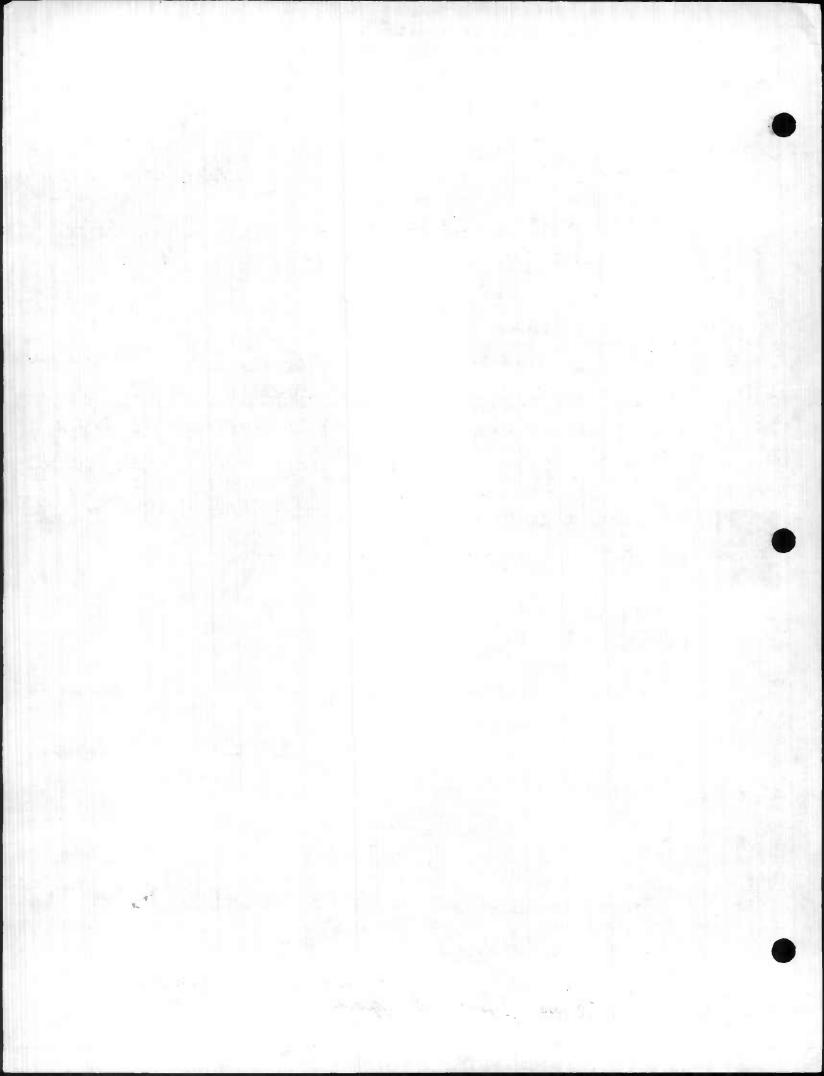
taner 32 Registrar's Signeture

of person who completed cause of death (ttem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

JULY 27, 1999



State of Maryland / Department of Health and Mental HygieneQ Q

Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Data of Death Day Physician Month Yaar RACHEL ANDERSON JULY 05, 1999 6:37 pm /Medical 4a. Fecility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MARINER NURSING HOME OF KENSINGTON KENSINGTON MONTGOMERY | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | Nort 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X K 73 **Director** 579-32-3617 Usual Rasidance of Decedent 10e. State 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits r than "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at Director MARYLAND XX Yes 2 No MONTGOMERY KENSINGTON 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Items 23a 3000 McComas Avenue pemit. Pages 1 and 2 should be filed within 72 hours after death 1. Department of Health and Mental Hygiene. traportant: If item 27 is marked other than "natural; or items 23a and Injury or other traumatic event, the Medical Examinal police. 20895 Funeral United States 12. Wes Decedant Ever in U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) Race - Amarican Indien, Black, Whita, etc. 1 ☐ Yas 2 🔯 No If Yas, Giva Yaar or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: by 3 Nidowed 4 Divorced Specify: Black Completed 15. Decedant's Education (Spacify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamentery/Secondery (0-12) Collaga (1-4or 5+) 9th Domestic Private 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middla, Maldan Sumama) Be N/A Willie Mae Nelson-Strother 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code) Rosemary Anderson Daughter 1500 Galen St. SE, Washington, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, Stata Data 1 Description 2 □ Cremation 3 □ Removal from State CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) FOREST HILL CEMETERY 07-10-99 22. Nama and Address of Facility
DUDLEY FUNERAL HOME 21. Signature of uneral Sarvice Licansa avous 3200 RHODE ISLAND AVE., MT. RAINIER, 20712 23a Part 1. Entar the diseasa, or complications that caused ha daeth. Do not antar tha moda of dying, such as cardlac or raspiretory arrest, shock, or haan feilura. List only one ceuse on aech ma. Approximate Interval Batween **Physician** /Medical Immediata Causa (Finei disaase or condition rasulting in daath) CEREBRAL INFARCTION ONE MONTH Examiner Physician/Medical Examiner CELEBROVASCUAR INVERICIENCY
Dua to (or as e consequence of): YEARS sician and bunal-transit The law requires that the death certificate be executed Sequentially ilst conditions, if eny, laading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initiated evants resenting in death) Last physician s the burial P.O. Box 68760, Dua to (or as a consequence of) Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 45 Unknown HYPERTENSION ATRIAL FIBRILLATION Records, þ page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy tindings sysilabla prior to completion of cause of daath? this certificate 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: director, 25. Was casa ratarred to medical axaminer? Be 26. Piaca of Daath (Chack only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No funeral 28e. Data of Injury (Month, Day Year) 27. Mannar of Daath 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Natural 2 Accidant 5 Panding Invastigation 24 hours after death.

Funeral Director: A 1 □ Yas 2 □ No 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, tarm, straet, factory, offica building, atc. (Spacify) filled in by 4 Homicida Hospital edical 15 Certifying Physician: To the best of my knowledge, daath occurred et tha time, data and placa, and due to the cause(s) and mannar as stated.
2 Medical Examinsr: On tha basis of axaminetion and/or invastigetion, in my opinion, death occurred et the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifier To the Hosp within 24 ho To the Fune completely fi 29b. Signetura end titla of certifier 29c. License number 29d. Deta signed (Month, Day, Year) July 6, 1999 D08944 30. Nama and addrass of person who completed clusa of daath (Itam 23e) (Type, Print) 3720 FALLAGUT AVE. KENSINGTON, MD-20895 C. SHARGEL G.M 32 Ragistrar's Signature 31. Data filed (Month, Day, Yaar)

JUL 13 1999 State Registrar

JUN 7 9 1338

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			Piease 1	Type or Pring State of Ma			t of I	lealth and I	Mental Hyg	iene) 9		3752
		1. Decedent's Neme (Fit	rst, Middla, Last,)					2. Date of Deat	ng. N o. h		3. Time of Death
Physici		7	ZACHARY	DAVID A	ASHLEY				Month JUL	7 199	Year 9	1:58 PM
/Medic Examin		4a. Facility Neme (If not NAT')		street and number)	CAL CENT	rer		4b. City, Town, or L BETH1		4c. County		
Funeral Director		5. Social Security Number	er 6. Sex		e (In yrs. last bii		1 Yeer Days	Hours Min.	8. Dete of Birth (Month, Day,	Year)	1	lece (State or Foreign
aryland show d.st		Usual Residence of Dec 10a. State 10b	edant c. County		10c. City, Tow	n or Location					1	Od. Inside City Limits
Se-1	cto		AIRFAX		ALEXAN							1 ☐ Yas 2 No
with th	Funeral Director	10e. Street and Number 5712 CLAPHA	M DOAD			10f. Zip			10	Og. Citizen of		itry?
23 married	eral	11. Meritel Stetus		12. Was Decedent I	Ever in 11 C	223		diamenia Origin? (Cr	pooiby Voc or No	U.S.A	e - Americ	en Indian
ours after deeth with the Marylan ral', or items 23s or 28s-f show Examiner ment be noticled at	þ	1 Never Merried 3 Widowed 4	2 Married	Armed Forcas? 1 Yas 2 N H Yes, Giva Yeer or Datas:		If Yes, spec		dispanic Origin? (Span, Mexican, Puerto Specify:	Pican, etc.)		ck, Whita,	atc.
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Medical Example or must be notified at once.	Completed	(Specify or Elamantary/Secondary	Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant's Education of the Indian Decedant of th	cation a co <i>mpleted)</i> College (1-4or 5	+)	Decedant's Usua (Giva kind of woi lifa. DO NOT us IEVER WOR	k done e retire	during most of world)	king	16b. Kind of B	usiness/inc	dustry
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d be f	o Be	BRADLEY K.							REBECCA			
shoul mark mark	10	19a. Informant's Name/I			196	. Mailing Address	(Street	and Number or Ru				Code)
and 2 ealth a n 27 is ner trai		BRADLEY K.	ASHLEY	(FATHER)	57	12 CLAPE	IAM	ROAD ALEX	KANDRIA,	VA 22	315	
Pages 1 ann of He int: If item		20a. Method of Dispositi 1 Deurial 2 Kra 4 Donation 5 D	emation 3 R	emoval from State	cemata	f Disposition (Namery, crematory or o	ther ple			99 (AL		own, Stata
Departm Importar any Injur		21. Signature of Funerel		98		22. Nema an	d Addre	ess of Facility DEA	AINE FUN	ERAL H	OME	
Depariment important	3 1	+	77		05			ICK RD. S				.51
Physician /Medical Examiner	ler	23a. Part1. Enter the disaasa, or complications thet caused the daeth. Do not antar the mode of dying, such as cardiec or raspiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceusa (Final disease or condition rasulting in death) TRISOMY 13 Due to (or as a consequence of):										
a executed an and urial-transit	Examiner	Sequantially list condition if any, leading to immad cause. Entar Undarlying	ons, liata		Dua to (or as a	consequence of):			-			
eath certificate be attending physicii for use as the bu	Medical	Cause (Disease or Injury thet initiated evants resulting in death) Last			Due to (or as a	consequence of):	·					
th ce tendii	an											
the d	by Physician/Medica	Part II. Other algnificant	conditions con	tributing to death bu	ut not resulting l	n tha undarlying c	ausa gi	van in Part I.		bacco use co se 2⊠ No		the cause of death? bably 4 Unknown
lew requires that the second s	Completed b								24a. Was ar perform	n autopsy ned?	av	ere autopsy findings allable prior to mpletion of cause death?
The la	Cor								113 Ye	s ZIXINO	10	TVes ZINO
ysician: The levis certificate hes	Be	25. Was case referred to examiner?		ار المجادة lospital: محم			-		th (Check only on	9)		
Q 60 X	-T	1 ☐ Yes 2 ☐ KNo 27. Manner of Death		1 LAInpatie			-	4 U Nursing H	oma 5 Raside			y)
anding i seth. or: After he fune	ation	tX□Natural 5[2 □ Accident	Pending invastigation	28a. Data of Injur (Month, Day	Year)	Time of 2 njury M	Bc. Inju Wo 1 □	rk? Yes 2 □ No	28d. Describe ho	w injury occur	rred	
To the Hospital or Attanding Physician: within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Sulcide 6 [4 ☐ Homicida	Could not be datarmined	28a. Place of Injubulding, etc.	ury - At home, fa :. (Specify)	rm, streat, factory	, office		28f. Location (Sti City or Town		ber or Rura	il Route Number,
n 24 hour	edical											
To th To th comp	X	29b. Signature and title	Sentiner	11		290	Licens	se number	25	d. Deta signe	d (Month,	Dey, Year)
	1	1/6	Ku	(/				D-44634		JU	10	8 1999

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

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R, MC, USN

CDR,

State Registrar J. R. GREENWALD,
31 Pate filed (Month, Day, Year)
JUL 13 1999

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Program and the same

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 2 3 7 5 3

					Cert	ificate of	Death	1.5	Reg. No.		P1
Physician	1. Decedent's Neme (F	First, Middle, L	ast)					2. Dete of D Month	Dey	Year	ime of Death
/Medical	Maria		Alban					July			:15 AM
Examiner	4a Facility Neme (if no.			ber)				or Location of Dea	111111111111111111111111111111111111111		
	Sacred He					if Under 1 Year	Hyatts		Princ	e Georg	ges
Funeral Director	5. Social Security Number 152–36–547 Usual Residence of De	6	Sex 1□M 201F	7. Age (In yrs. I 89	Yrs.	Months Deys		in. Feb.	ay. Year) 2, 1910	9. Birthplace (Country) Italy	State or Foreign
death with the Merylend ms 23a or 28s-f show count to notified a	10e. Stete 10	b. County		10c. City	, Town or Loc	ation					side City Limits Yes 2 □ No
Serie Me	Maryland F		Georges	La	nham						25 162 2 140
or 2	10e. Street and Numbe	or				10f. Zip Code			10g. Citizen of W		
ath w	6515 Green	nfield					20706		U.S.A		
or its		_	12. Was Dece Armed For 1 Yes If Yes, Give Yeer or De)		as Decedent of I Yes, specify Cub		(Specify Yes or Nerto Rican, etc.)	Bleck	White	aign,
"natural", or edical Exam	15.	. Decedent's E	Education		16e. Decede	nt's Usuel Occu	pation		16b. Kind of Bus		
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id be ental ked c		Alba	nese				Giaco	omina D'A	niello		
should and Men marke emarks	19e. Informent's Name	/Reletionship	(Type, Print)		19b. Meiling	Address (Stree	t end Number or	Rurel Route Num	ber, City or Town,	Stete, Zip Code)
1 end 2: Health av em 27 le rither treu	Giuliana I	DeRober	tis (Dau	ghter)	6515	Greenfie	eld Ct.	Lanham,	MD 20706		
emit. Peges 1 e Separtment of He mportant: If item ny Injury or othe	20e. Method of Disposit				ace of Dispos	ition (Name of story or other ple	ica)	Dete	20c. Location - 0	City or Town, S	tate
Pege ent o ry or	1 X Burlei 2 C 4 Donetion 5			tete				7/16/99	Silver S	Spring.	MD
permit. Pages 1 and Department of Health Important: If item 27 eny Injury or other tr once.	21. Signeture of Coner	el Servica Lice	ensee					neral Hom		JP 2 2 1 6 7	
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Name and Address of the Owner, where	23a, Page . Enter the d	disease, or cor	mplications that ca	used the deeth						Appl	oximete
Physician /Medical	Immediate Cause (Find disease or condition	/	y cause on ea		te cere	Sov	ascul	ir acc	ident	Onse	vel Between et end Deeth
Examiner	resulting in deeth)		a		es e consequ					1	
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icate be executed physician and sthe buriel-transit	Sequentielly list conditi if eny, leeding to imme cause. Enter Underlyir Cause (Disease or Inju	ng III		mus	lopt	hisic.	Junde	ome			gears
licate be expression is the burie	thet initieted events resulting in deeth) Lest		С.		es e consequ						
of Se of			l d								
deeth certi			Q							1	
	Pert II. Other significan	nt conditions	contributing to de	ath but not resu	Iting in the un	derlying cause gi	iven in Pert I.	23b. Di	tobacco use con	tribute to the	cause of death
± × 5	500	10	lement	. 5				10	Yes 2 No	3 Probably	4 Unknow
8 8 8 G		VIE O	Jenn Ca	1 4						Odb Mars a	damas dia dia na
requires hould be								24a. We	s an sutopsy formed?	available	topsy findings a prior to ion of cause
S 2 3								_		of death	?
- 20 -								10	Yes 2770	1 ☐ Yes	2□ No
F # 8 0		to medical						Death (Check only	one)		
F # 8 0					ER/Outpatient	3LI DOA			sidence 8 Othe		
	25. Was case referred examiner? 1 Yes 2 No			f Injury	28b. Time of Injury	28c. Inju		28d. Describe	how injury occurr	ed	
hysician: The his certificate all director, pe	25. Was case referred examiner? 1 Yes 2 No	5 ☐ Pending	28a. Date of (Month	i, Day rear)		M 1	Yes 2 No				
ing Physician: After this certific funeral director	25. Was case referred examiner? 1 Yes 2 No	investigati	on be	i, Day rear)							
Ing Physician: Th. After this certificate funeral director, pe	25. Was case referred examiner? 1 Yes 2 No		on be 28e. Piece		me, ferm, stre	et, fectory, office			(Street and Number own, State)	er or Aural Aou	te Number,
Ing Physician: Th. After this certificate funeral director, pe	25. Was case referred examiner? 1 Yes 2 No	investigation in	on be 28e. Plece buildir	of Injury - At ho g, etc. (Specify	")			City or T	òwn, Stete)		
Ing Physician: Th. After this certificate funeral director, pe	25. Was case referred examiner? 1 Yes 2 No	investigation Could not determine	be 28e. Plece buildir	of Injury - At hog, etc. (Specify	viedys, deall	occurred at the t	ime, date and pi	City or T		nner as stated.	
Ing Physicien: Th. After this certificate funeral director, pe	25. Was case referred examiner? 1 Yes 2 No 27. Menn Deeth Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only one)	investigation Could not determined Countying P Medical Exa	be 28e. Plece buildir	of Injury - At hog, etc. (Specify	viedys, deall	occurred at the testigation, in my	ime, date and pr opinion, death o	City or T	own, State) cause(s) and ma date and place, s	iner as stated, and due to the	Cause(s)
Hospital or Attending Physician: The March of March Called Physician Funeral Director: After this certificate tely filled in by the funeral director, per Mical Certification: To Be Co	25. Was case referred examines? 1 Yes 2 No 27. Menn Deeth Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier 1 (Check only one)	investigation Could not determined Countying P Medical Exa	be 28e. Plece buildir	of Injury - At hog, etc. (Specify	viedys, deall	estigation, in my	ime, date and propinion, death o	City or T	own, Stete) cause(s) and ma e, date and place, a 29d. Date signed	and due to the	cause(s) Year)
Ing Physicien: Th. After this certificate funeral director, pe	25. Was case referred examiner? 1 Yes 2 No 27. Menn Deeth Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only one)	investigati	28e. Plece buildir hysician: To the ba and mann	of injury - At ho g, etc. (Specify best of my knows sis of examinat er stated.	r) wiedਪੂਰ, ਹੋਦਕਸ਼ ion and/or inve	estigation, in my	ime, date and propinion, death o	City or T	own, Stete) cause(s) and ma e, date and place, a 29d. Date signed	and due to the	cause(s) Year)
Ing Physicien: Th. After this certificate funeral director, pe	25. Was case referred examiner? 1 Yes 2 No 27. Menn Deeth Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only one)	investigati	be 28e. Plece buildir	of injury - At ho g, etc. (Specify best of my knows sis of examinat er stated.	r) wiedਪੂਰ, ਹੋਦਕਸ਼ ion and/or inve	estigation, in my	ime, date and propinion, death o	City or T	own, Stete) cause(s) and ma e, date and place, a 29d. Date signed	and due to the	cause(s) Year)
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Registrar

production and production of the second of t

12. Was Dacedant Ever in U,S. Armed Forces?

1 ☐ Yas 2 No If Yes, Give Yaar or Datas:

College (1-4or 5+)

7. Aga (In yrs. lest birthday)

10c. City, Town or Location

Salisbury

65

Days

10f. Zip Code

1 Yes 2 No

21801

Shucker

Houra

Specify

Sarah M. Armwood

10b. County

Wicomico

1010 Fairground Dr., Apt. 4

15. Decedent's Education (Specify only highast greda complated)

1 Burial 2 Cremation 3 Removal from State

5. Social Sacurity Number

217-30-8663

10e. Street and Number

11. Marital Status

10a. State

Usual Residence of Decedent

1 □ Nevar Married 2 □ Married

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

Duey Horsey

20a. Mathod of Disposition

17. Fathar's Nama (First, Middla, Last)

19a. Informant'a Name/Relationship (Type, Print)

Marilyn Ware/daughter

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service L

4a Facility Nama (If not Institution, giva street and number)

PENINSULA REGIONAL MEDICAL CENTER

1 ☐ M 25 F

24b. Were autopsy findings available prior to

completion of causa of death?

1 Yea 2 No

24a. Was an autopsy performed?

28d. Describe how injury occurred

Other: 4 Nursing Homa 5 Residence 8 Other (Specify)

28. Placa of Death (Check only one)

20 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

29d. Date signed (Month, Dey, Year)

hours after Maryland 21215-0020 Hygiene. permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient important: if frem 27 ie marked other tru any fulury or other traumatic event, traupologie. altimore,

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

Directo

Funeral

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T is marked other than "natural", or items 23s or 28s-f show traumstic event, the Market Examiner must be notified at

natural, or

Physician/Medical Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the signed by Completed by The certificate Physicien: Be 10 this funeral Certification: After t or Attending To the Funeral Director: Aftromeral Director: Aftro Hospital edicai

Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not anter tha mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to Immediata cause. Enter Underlying Cause (Disease or Injury that Initiated evants Due to (or as a consequence of) Due to (or as a consequenca of): resulting in death) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23h Did tobacco use contribute to the cause of death? No No 1 Yes 3 Probably 4 Unknown

2 ER/Outpatient 3 DOA

28b. Time of

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

20b. Place of Disposition (Neme of cemetary, cremetory or other place)

Backbone Hill Cemetery

Registrar

31. Date filed (Month, Dey, Year) JUL 0 8 1999

25. Was case referred to medical axaminer?

1 Yes 20 No

27. Menner of Death 1 (SNatural 2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

Hospital:

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

5 Panding investigation

8 Could not be determined

1 Inpatiant

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

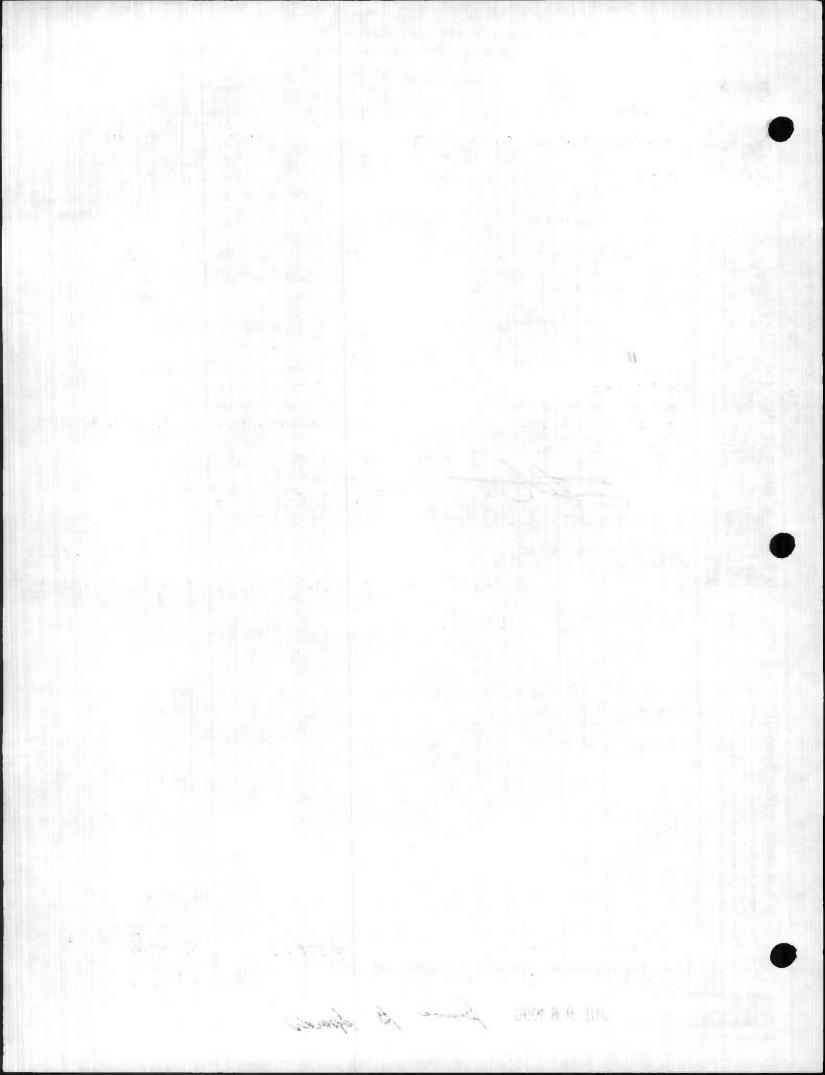
E. (MOIL A

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es atated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

28c. Injury at Work?

29c. Licensa number

1 Tyes 2 No

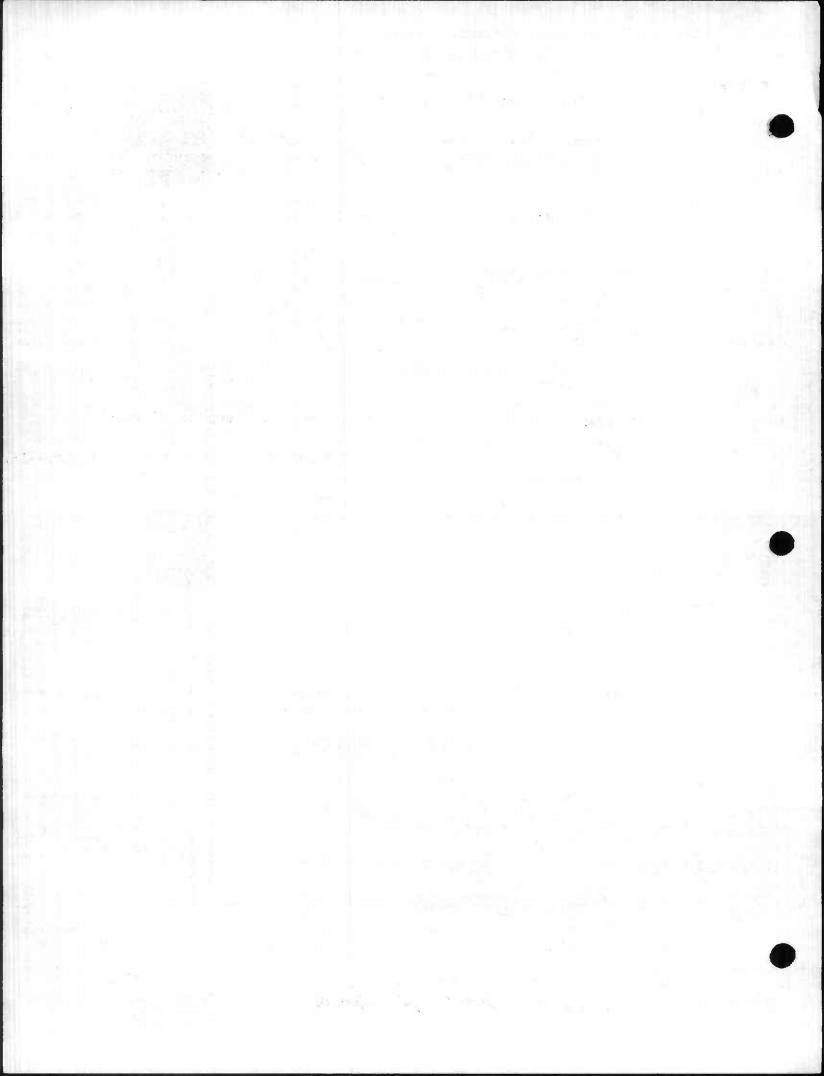


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State of Maryland / Department of Health and Mental Hygiene 9

						Certifica	te of I	Death	F	Reg. No.	fixed	0 / 0 0	
	Physici	an	Decedent's Neme (First, Middle, Las MARY	FRANCES	ARE	BOTT			2. Dete of Dee Month		Yeer	3. Time of De	
14	/Medic	al	4a. Facility Neme (If not institution, give) ADI	5011	4	b. City, Town, or Lo	07		19 99	22:2	0
	Examir	ier	Dorchester		lospital			Cambridg			ester		
	uneral irector		5. Sociel Security Number 6. Security Number 113 - 24 - 4878	7. Age	(In yrs. last birtl	hdey) If Und Months	er 1 Yeer s Deys	If Under 24 Hrs. Houra Min.	8. Dete of Birth (Month, De) Sept 6	, Year) 1929	9. Birthple Count Mary]	ece (Stete or Forty) and	oreign
pug	ž.,,		Usuel Residence of Decedent 10a. State 10b, County		10c. City, Town	or Location					10	d. inside City L	lmits
Manyl	Media	tor	MD Dorche	ĺ	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cambr	idge					12 Yes 21	
S with the	23e or 28 unt be not	Funeral Director	10e. Street and Number 503 Mu i	r St.		10f. Z	ip Code 21	613		10g. Citizen of V	Vhat Count	ry?	
21215-0020% d within 72 hours efter dea	7 is marked other than "natural", or frems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at	6	11. Meritei Steius 1 □ Never Merried 2 □ Merried 3 □ Widowed 4 ◘ ♥ ivorced	12. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		13. Wes Dec if Yes, sp 1 Yes	1	spenic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bled	e - America k, White, e White	tc.	
5-0 72 ho	natur	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. l	Decedent's Us (Give kind of w	rork done o	turing most of worki	ng	16b. Kind of Bu	usiness/Inde	usiry	
within within ane.	Da Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. DO NOT bookk		•		amuseme	ent ve	endor	
D Filled	off.	Be Co	17. Fether's Neme (First, Middle, Last)	,,	<u> </u>			18. Mother's Neme					
Vlar Wenta	rked rtic ev	To B	Isaa	ic Du	ıkes			I	Ruby A	Ignes	Marsh	nall	
, Mar and 2 sho	27 is mer traum		19a. Informant's Name/Relationship (7 Mamie Rossy — fr		19b. 31	Malling Addre	eys S	ond Number or Rura Spur Rd.,	Cambric	r, City or Town,	State, Zip (21613	Code)	
Baltimore, Maryland emit. Pages 1 and 2 should be file Department of Health and Mental Hy	Important: If Item 27 is any injury or other tra- once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Plece of cemetery Sal	Disposition (N r, cremetory or LSbury	eme of other plea Cre	e) matory		20c. Location - 9 Sali			
Balti permit.	Importa any inju once.		21. Signeture of Finerel Service Licens	01	9	1		ss of Fecility Tho				A	
			23a. Pert1. Enter the disease, or comp shock, or heert feilure. List only of	ilcetions that caused if	he death. Do n						T	Approximate Interval Between	00
	sician edical		immediete Ceuse (Finel	· Metos							i	Onsei end Dea	ith
Exa	miner	<u>.</u>	disease or condition resulting in death)		ue to (or es e c							WO MIN	11/4
ords, P.O. Box 68760, requires that the deeth certificate be assecuted	sician and burial-transit	cal Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause Disease or injury that miliated events.	C	ue io (or es e c								
ox 687	nding phys use as the	/Medical	resulting in death) Last	d	ue to (or as a co	onsequence of):						
. Box	o tt	icia	Pert il. Other eignificant conditione co	ntributing to deeth but	not resulting in	ihe underlylno	causa niv	en in Pert i	23b. Did to	obacco use co	ntribute to	the cause of d	leath?
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()	s been sign 2 should be	Completed b							24e. Wes a	an autopay med?	ava	re autopsy find llabie prior to apletion of caus eath?	_
œ ª	pag	Com							1 🗆 Y	es ZONO	10	Yes 2□ No	
of Vita Physician:	is certificate director, pag	Be	25. Wes case referred to medical examiner?	Hospitel:			Oth	26. Plece of Deeth	(Check only o	ne)			
on of	After this funeral di	tion: To	27. Menner of Death	28e. Dete of injury (Month, Dey			28c. Injun Work	4 LI Nursing Ho		ence 6 Doth)	
Division To the Hospital or Attending within 24 hours after death.	Director: d in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e, Plece of Injur building, etc.	y - At home, fer (Specify)				28f. Location (S City or Tow	itreet and Numb m, Stete)	er or Rural	Routs Number	,
Hospits 24 hours	To the Funeral Dir completely filled in	edicai C	29e. Certifier (Check only one) **Certifying Physical Example (Check only one) **Tertifying Physical Example (Check one) **Tertifying Physical Example (Check one) **Tertifying Physical Example (Check one) **Tertifying Phys	alcian: To the best of nar: On the besis of e end menner stete	xaminetion end	deeth occurre /or investigeild	d at the tim on, In my or	ne, date end place, o pinion, deeth occurre	end due to the ded at the time, o	eause(s) and ma dete end piece,	inner as sta and due to	ited. the ceuse(s)	
To the	Toth	Me	29b. Signeture end title of certified	ıl		2	9c. License	number	2	29d. Dete signe	d (Month, D	Pay, Year)	
) Jaw Ju	120			04	17924		7-14	-99		
			30. Name and eddress of person who company TIFA Nu	ompleted cause of dee	eth (item 23e) (T	Sype, Print)	(- C	inumber 17924 Cambrid	ege N	40 21	613		
	Sta Registr	te ar	31. Dete filed (Month Day, Year 6 19	32. 80	Signature	O. A.	oork	V					

Mary Frances Abbott



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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١.	407	-	from	0	8	0	1

Year

3. Time of Death

9. Birthplaca (State or Foraign Country)

10d. Insida City Limits

Approximete Interval Between Onset and Deeth

24b. Were autopsy findings available prior to

completion of cause of death?

2□ No

1 X Yes 2 No

07:05 AM.

Physician
/Medical
Examiner

Funeral Director

28a-f show rai", or items 23a or 28a-f ahov Examiner must be nothed at the WITH deep Peges 1 and 2 should be filed within 72 hours after cent of Heelth and Mertel Hygiene.
ant: if Item 27 is marked other than "natural", or fies
any or other traumatic avent, the Medical Empire,
any or other traumatic avent, the Medical Empire.

21215-0020

Baltimore, Maryland

P.O. Box 68760.

Records,

Division of Vital

Physician /Medical Examine

sician and burial-transit The law requires that the death certificate be executed physician the burie been signed the should be det page 2 has certificata or Attanding Physician: director. this funeral After after death. Director: Af filled in by

2. Deta of Death 1. Decedent's Nema (First, Middle, Last) Month Day July 11 1999 LEOLA S. BENTLEY 4s Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 245 Harry S. Truman Drive Apt. # 23 Prince George's Largo 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 8. Sex Months Days 1 M 2 XF 49 579-66-9637 April 16,1950 Washington, D.C. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location Upper Marlboro Director Prince Georges 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 U.S.A. #23 245 Harry S. Truman Drive, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedent Evar in U.S. Armed Forcas? 14. Race - American Indian, Bleck, White, etc. TYPAS 2□No 3/77-1 Nevar Merried 2 Merried Specify: Black 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 🖾 Divorced 6/77 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elementary/Secondery (0-12) College (1-40r 5+) Orkand Corp. Unknown 18. Mothar's Nema (First, Middle, Maiden Sumeme) 17. Father's Nema (First, Middla, Last) Be Helen R. Watkins Madison J. Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6820 Apt. F Town Brook Dr. Baltimore MD 21207 Michael J. Bentley, Jr.- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pege Department of Important: If any Injury or once. Maryland Veterans Cem 7-15-99 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011 Mars 23a P9/1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart leilure. List only one cause on each line. immediata Causa (Final disaesa or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immadiete cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as e consequence ot) Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24a. Was en autopsy 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home XXResidence 6 Other (Specify) 1X Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding 1 Tas 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signatur title of certifian 29c. License number 29d. Deta signed (Month, Dey, Year) O.C.M.E. JUly 12, 1999

State Registrar

completely

31. Date filed (Month, Dey, Year) 16 1999

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

at death (Item 23a) (Type, Print)

hours Hospital 24 hours

To the Within 2 To the I

Bar Ba Alle

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month CHARLES E. BROOKS 1130 AM 1999 July 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Prince Bowle 4906 Collington Koad If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, 6. Sax 12 M 2□ F 5. Social Security Number Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Days 93 Yrs 717-07-6692 Maryland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4906 Collington Road 20715 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 S No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 No Specify: 3 Widowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 3rd Senior Machine Operator Private 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Louis Brooks Lucy Griffen 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Jerome L. Brooks/Son 13304 8th Street, Bowie, Maryland 20715 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 07/17 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 1999 5 Othar (Specify) Resurrection Cemetery 4 Donation Clinton, Maryland 22. Nama and Addrass of Facility J.B. JENKINS FUNERAL HOME 21. Sign ure of Funaral Sarvice Licensaa ry 7474 Landover Road, Landover, Maryland 20785 11. Entar tha disaasa, or compile of his that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Immadiata Cause (Final disaasa or condition rasulting in daath) Arterioscherotic Cardio unseulas Disease Sequentially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasuiting In daath) Last Dua to (or as a consaquance of). Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medicai Examiner

Physician

/Medical

Examiner

Directo

þ

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumetic avent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelith and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic avant, The Madical Emerina

Baltimore, Maryland 21215-0020

Box 68760

P.0.

deeth

Examiner

certificate be executed physician and s the burial-trans 89 980 signed by t certificate or Attending Physician: after death. Director: After this certifica funeral

Physician/Medical à Completed Be 2 Certification:

Medical

27. Mannar of Death

1 Natural

2 Accidant

3 Suicida

29a. Cartifian

4 Homicida

Division of Vital Records, Hospital of 24 hours a within 2 To the

> State Registrar

1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 25 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifian 29c. Licansa number 29d. Date signed (Month, Day, Year)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Dascribe how Injury occurred

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 3001 Do

Drine, Cheverly,

vster 31. Data filed (Month, Day, Year)
JUL 1 6 1999

5 Panding invastigation

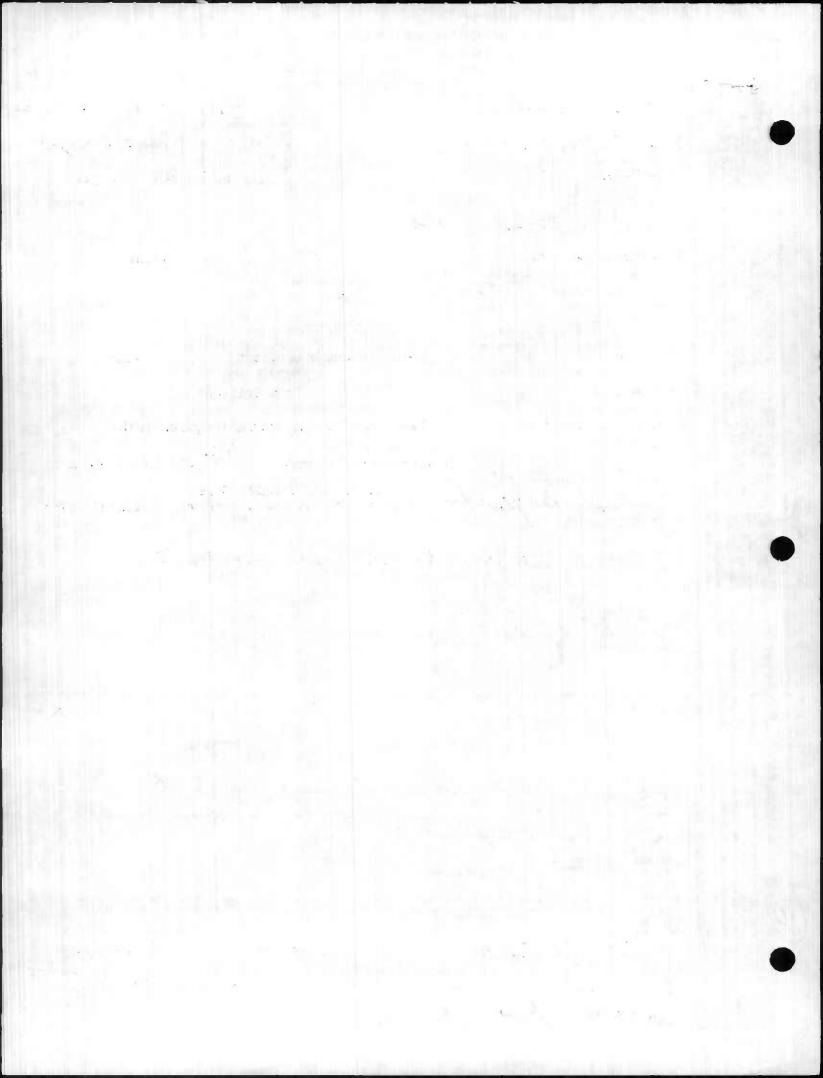
6 Could not be datarmined

32. Registrar's Signatura

28a. Date of Injury (Month, Day Year)

28b. Time of

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 23758

				Ce	ertificate of	Death	Re	g. No.		
		1. Decedent's Neme (First, Middle, L	ast)				2. Dete of Death Month		Year	3. Time of Death
	Physician /Medical	Rhoda E	lla E	Barham				1, 199		2:40 pm
	Examiner	4e Facility Name (If not institution, g	ive street and number)			4b. City, Town, or L	ocation of Death	4c. County of	of Death	
A .		Sacred Heart N	ursing Home			Hyattsvi	.11e	Princ	e Ge	orge's
	Funeral Director	213-56-4438	·	s. last birthday 6 Yrs.	Months Days		8. Data of Birth (Month, Day, June 5,	Year) 1913	Coun	lace (State or Foreign stry) yland
	Pu &	Usual Rasidence of Dacedent 10a. Stata 10b. County	100	City, Town or L	noution				1	0d. Insida City Limits
	death with the Maryland rms 23s or 28s-f show rmust be notified st neral Director	Maryland Prince			tsville					Yos 2 No
	23ª or 2	10e. Street and Number 5805 Queens Chap	el Road		10f. Zip Coda 207	82	10	U.S.A		stry?
Maryland 21215-0020	urs efter Examine by Fur	11. Marital Stetus 1 ☐ Nevar Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	12. Was Dacedent Ever in Armed Forcas? 1 Yes 2 No If Yas, Give Yeer or Detes:	U,S. 13	Wes Decedant of If Yes, specify Cub	Hispanic Origin? (Sp an, Mexicen, Puerlo Specify:	ecify Yas or No- Ricen, etc.)		c, White,	an Indien, atc. ite
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Baltimore,	Pages nent of int: If it iry or	1 X Burlal 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec	ify) Ger	orge Was	hington Ce	metery (07/14/99			
Bal	pemit. Pag Department Important: I any Injury o	21. Signatura of Funeral Service Lice	te 2. Das		22. Name end Addr asch's Fu 739 Ralti	ess of Fecility Ineral Hom Imore Aven	e, P.A.	tsville	MI	20781
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7	/Medical	Immediata Causa (Final diseesa or condition	Preve	moni	u					48hrs
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Division of Vital Records,	> 00	Senile dem Rhemator	d arthritis				24a. Was ar perform	n autopsy ned?	av	ere autopsy findings allable prior to impletion of cause death?
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ta	certificete rector, pag	25. Was case referred to medicet				29 Place of F	th Check on one			3 163 2 3 140
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	To the Hospital or Attent within 24 hours after deat within 24 hours after deat to the Funeral Director: completely filled in by the Medical Certifical		hyelclan: To the best of my k iminer: On the basis of axami and mannar stated.							
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	(3)	30. Nama and addrass of person who				m Dandan	04+- /0	0 0	1. 7	+ MD 20770
	State	Peter M. Schissle 31. Deta filed (Month, Day, Yaar)	32. Ragistrar's Sig	natura			Sulte 43	u, Gree	nbel	.t, MD 20//U
	Registrar	JUL 1 3 1999	Cultura	D.	Spark					

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State of Maryland / Department of Health and Mental Hygiene 99 23759

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ysician		. Decedent's Nam	ne (First, Midd	lie, Last)								2. Data of De Month	eath Day	Yaar	3. Time of	
Medical		Nora S	S. Buck	clew								Ju1y		999	4:20	A.M
aminer	48	Facility Name (1000						4b. City, To	wn, or Lo	cation of Deat	h 4c. County	of Death		
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eral ctor		Social Security 1		6. Sax	7. A	ge (In yrs.	last birthday Yrs.	Month:	ar 1 Year S Days		24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year) 5, 1925	9. Birthp	place (State ontry)	r Foreign
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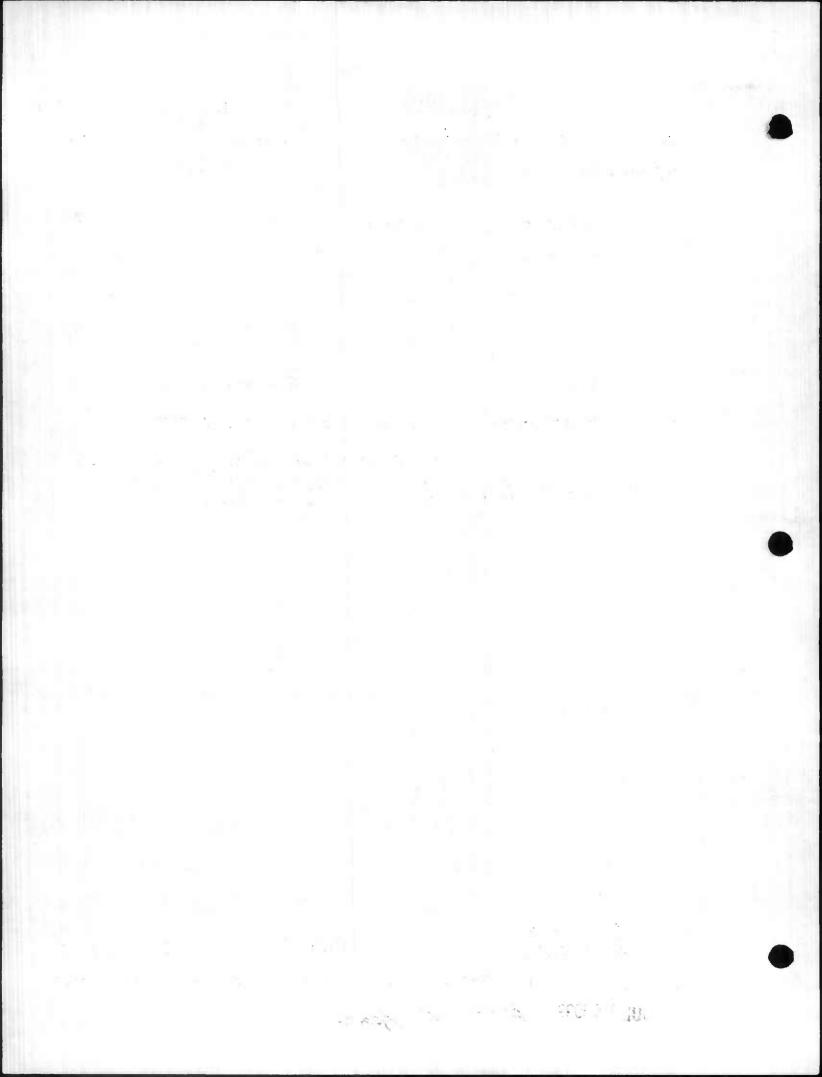
State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Deeth 3. Time of Deeth **Physician** Rell Month HoraLR 1202 pm July 13 /Medical 4a. Fsclifty Nama (If not institution, giva street and number), 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Medical Baltimore Center Baltimore Baltimore If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. 8-30-20 5. Social Security Number Birthplace (State or Foreign Country)
 N.C. 7. Age (In yrs. last birthday) **Funeral 1** M 2□ F 243-40-6596 Yrs. 78 Director Usual Rasidance of Decedant permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Madical Expriner must be notified at ODGs. 10e State 10b County 10c. City. Town or Location 10d. inside City Limits 1 Yes 2 No Director Baltimore City Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zlp Coda U.S.A. 939 Ashburten Street 21216 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1₩ Yes 2 □ No If Yes, Give Yaar or Datas: 14. Race - Amarican Indien, Black, Whita, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Maxican, Puarto Rican, atc.) 11. Maritel Stetus 1X Never Merried 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: Black h 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) N/A 12th Mechanic 17. Fethar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) EINORA DeWitt Bell BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 939 Ashburten St., Balt., Md. 21216 Sophia Hopkins/Daughter 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition Dste 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Enfield Memorial Cem. 7/17/99 Enfield, N.C. 22. Name and Address of Facility Bianchi Funeral Service c/o Hackett's Funeral Chapel, Inc. 21. Signature Funaral Sarvice Licensee Fent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate iritarval Between Onset and Death **Physician** Esophageal /Medical Immediata Causa (Final Cancer 6 months diseasa or condition rasulting in death) Examiner Examiner signed by the attending physician and d be detached for use as the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inflated events resulting in death) Last Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Gastro intestinal 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown þ 24b. Wara autopsy findings svallable prior to complation of cause of death? Completed 24a. Was an sutopsy performed? 1 Yas 2000 1 Yes 2 TNo To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certifica Be 25. Was case refarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yas 2 No P 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Describe how Injury occurred Certification: 5 Panding investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datermined 3 Sulcide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 29a, Certifler Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29b. Signature englittle of certifiar 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) 10 N. Greene St. BVAMC Reltimore MD Javan Gordman M.D. 21201 31. Data filed (Month, Day, Year)
JUL 1 4 1999 82. Registrar's Signeture State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2 Data of Death Month **Physician** lian 1 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Atlantic General Hospital Worcester If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) March 30, 19 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2XF Months Days Hours Min 84 Yrs. 1915 Washington, DC 220-28-5774 Director Usual Rasidance of Decedant the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits tem 27 le marked other than "naturel", or items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Directo Maryland Prince George's Bowie 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 20720 8503 Brent Court U.S.A. Funeral 14. Race - Amarican Indian, 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status Black, White, atc. e liled within 72 hours after al Hygiene. other than "naturel", or ite 1 ☐ Yas 2 X No It Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: by 3 X Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Steamfilters & Plumbers Elamantary/Secondary (0-12) Collaga (1-4or 5+) Union Headquarters Keypunch Operator 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) 12 should be it and Mental H Lusby Lillian M. Harvey Harry 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Ie m any Injury or other traum page. Marlene B. Cleveland - Daughter 8503 Brent Court, Bowie, Maryland 20720 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 DI Burial 2 Cramation 3 Ramoval from Stata 07/16/99 4 ☐ Donation 5 ☐ Othar (Specify) Cedar Hill Cemetery Suitland, Maryland 21. Signatura di Funaral Sarvice Li sin aa 22. Nama and Addrass of Facility Gasch's Funeral Home, P.A. 23a. Part. Enter the rise is a, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tay a. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximata Intarvsl Between Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) Infarction Examiner Dua to (or as a consequence of): Examiner ician and buriel-trans Sequantially list conditions, if any, leading to immadiata causa. Entar UndarlyIng Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence ot): physician Physician/Medical the Dua to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 | Inpatient 2 | Outpatient 3 | DOA Certification: To 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 5 Pending Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 6 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) To the To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 048130

Healthway Drive Berlin, MD 21811

Registrar

30. Name and andress of person who complated causa of death (Itam 23a) (Type, Print)

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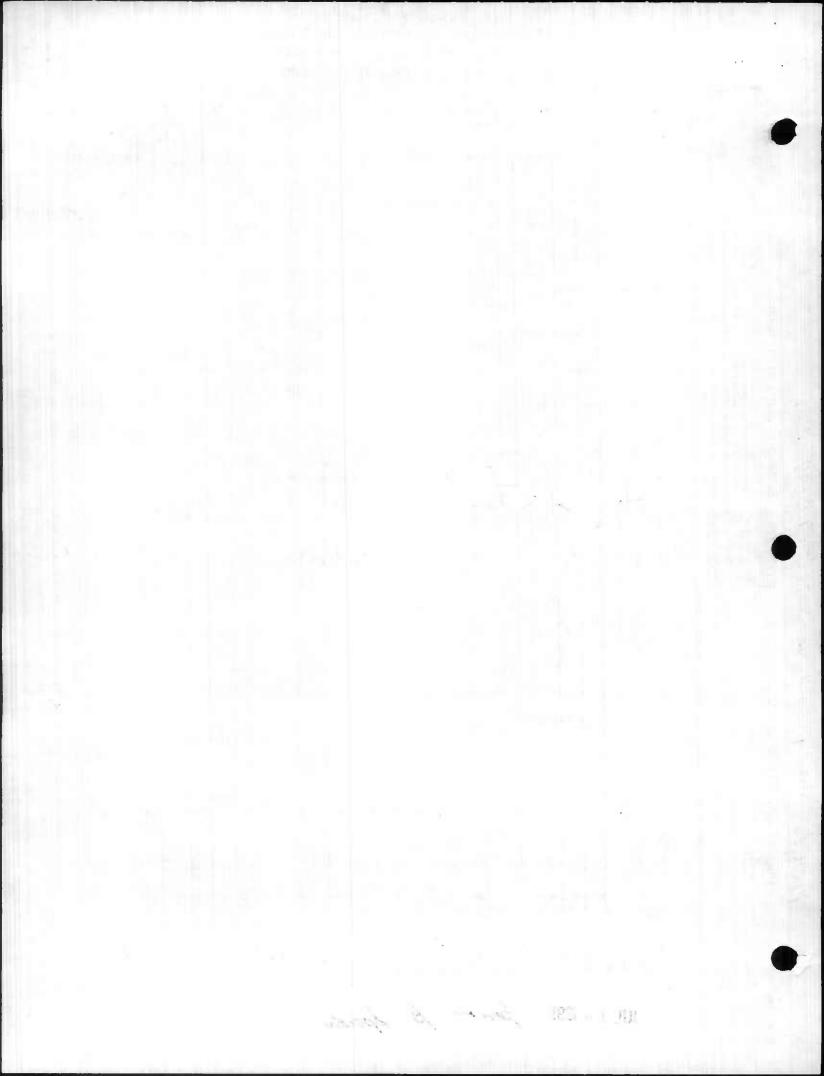
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7-13-99



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Certificate of	of Death	Reg.	No.	.3/62
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ennium Nursing Home	4b. City, Town, or Loc Baltimo	cation of Death	4c. County of Deeth Baltimo	re

Physician /Medical **Examiner** 1. Decedent's Neme (First, Middle, Last) Phillip Brown

4e. Fecility Neme (If not institution, give st. Northwest Mill

5. Sociel Security Number 579 – 38 – 0297 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Depth, Day, Year 9 29 Washin, D.C. 6. Sex **Funeral** 10XM 2□ F **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location Washington 10a State 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2□No Director 10f. Zip Code 20010 10g. Citizen of Whet Country? U.S.A. 10e. Street and Number ծ 1344 Perry Place N.W. Items 23a by Funeral death 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X0 o If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Eventier once. 130 Never Merried 2 Married Specify: Afro-American Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Private Elementery/Secondery (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Mary Butler Fred Brown 19a. Informent's Nerne/Reletionship (Type, Print) Albert Brown 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Perry Place N.W. Wash., D.C. 20010 20e. Method of Disposition 20b. Plece of Disposition (Name of July 20, 1999 Wash. D.C. Mt Olivet Cemetery Buriai 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
Robinson Funeral Home
1313 6th St. N.W. Wash.D.C. 20001 21. Signeture of Funeral Servica Licensee Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medicai immediete Ceuse (Finel Congestive Heart Failure diseese or condition resulting in deeth) Examiner Old Cerebro Vascular Accident Examiner To the Hospital or Attending Physician: The law requires that the death certificate be asscuted within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filed in by the funeral director, page 2 should be deteched for use as the burlansit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Chronic Obstructive Lung Disease Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Schizopherinia 3 Probably 4 ☐ Unknown 1 ☐ Yee 2 ☐ No Completed by 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Yes 2X No 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Neturei 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homleide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, dete end pleca, end due to the cause(s) end menner stated. 29e. Certifler Medical 29b. Signeture end title of certifier

Pforme - Al- Harnid , MD 29c. License number D52842 29d. Dete signed (Month, Day, Year) July 13, 1999 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Asma-Al-Hamid, MD 501 Dolphin Street, baltimore, MD 21217

State Registrar

31. Dete filed (Month, Dey, Year) JUL 1 6 1999 32 Registrer's Signeture

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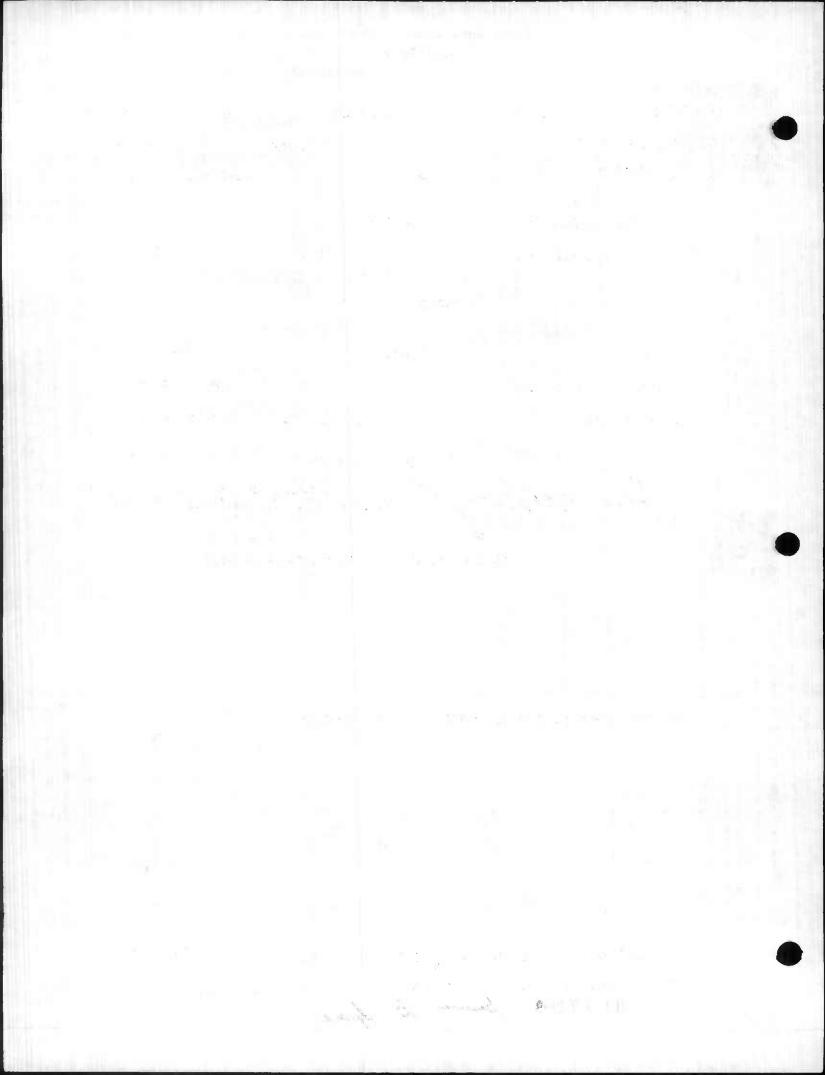
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	or 284	Director	10e. Street end Number	_		10f.	Zip Code	074		10g. Citizen of	Whet Country	?
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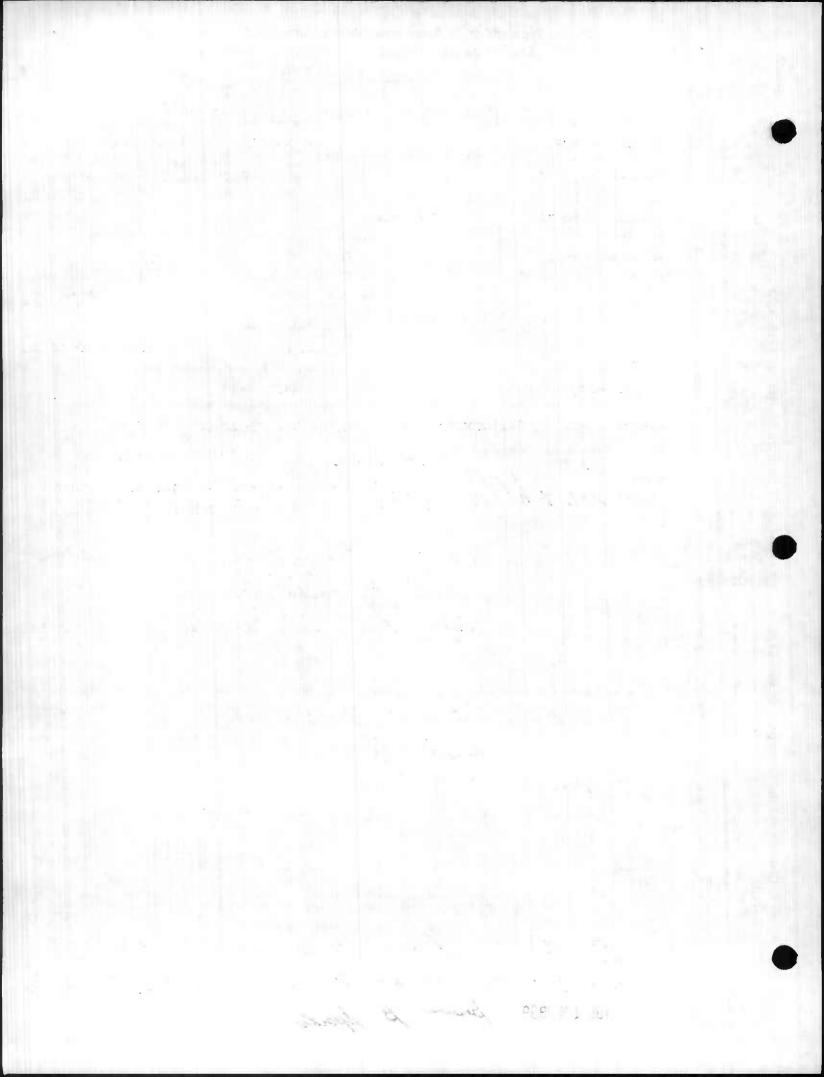


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State of Maryland / Department of Health and Mental Hygiene 99 23764

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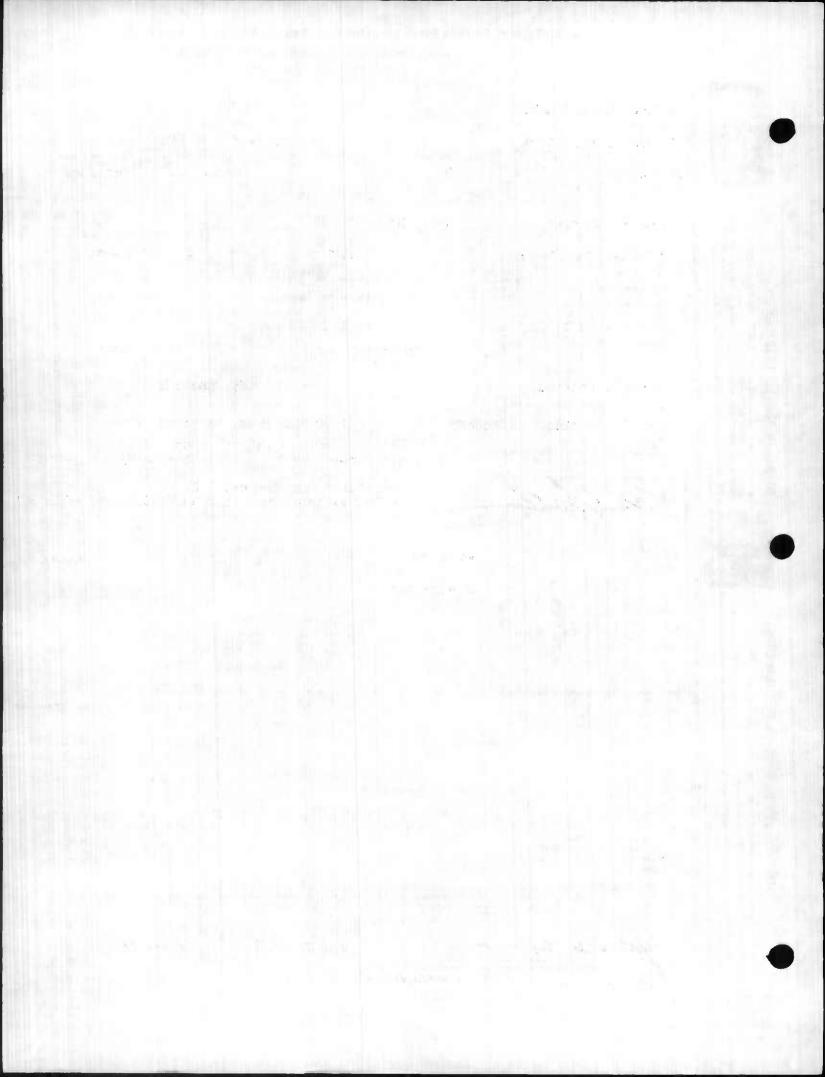


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State of Maryland / Department of Health and Mental Hygiene 9 9

AMEND ITEMS: #28A-F PER MEO G776 10-6 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** July 14, 1999 3:25 p.m. Arthur Allan Comstock /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give straet end number) Examiner Charles Indian Head 18 Indian Head Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Sociei Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** XXM 20 F Months Days Hours Yrs. 217-50-9020 50 October 5,1948 Maryland Director Usuel Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 □ No Directo Maryland Charles Indian Head 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with r than "natural", or items 23a or the Medical Examiner must be United States 18 Indian Head Avenue 20640 Funeral filed within 72 hours after death Hygiena. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: Wes Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien. Bleck, White, etc. 1X Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16b, Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) 16a, Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) Realtor/Owner Real Estate 4 12 should be filed w h and Mental Hygie Is marked other ti 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) Ruth Moody Comstock Arthur E. Comstock 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 2 st Department of Health and Important: If Item 27 Is in any Injury or other treun page. 9 Pine St., Indian Head, Maryland 20640 Ruth M. Comstock Mother July 17, 1999 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Charles Cemetery Indian Head, Maryland 22. Nema and Address of Fecility 21. Signeture of Funaral Sarvice Lansee Williams Funeral Home, P.A. 4270 Hawthorne Road, Indian Head, Maryland 20640 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or here failure. List only one cause of mach line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disasse or condition resulting in deeth) Inknown Asphyxia Examiner Due to (or es e consequence of): Propane Gas Examin physician and s tha bunal-transit tha death cartificata be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): Box 68760, Physician/Medical that initiated events resulting in deeth) Lest Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o signed by t d be datach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown requires that Records, þ 24b. Were autopsy findings available prior to completion of cause of death? should 24a. Wes en autopsy Completed peen aw has Ple Ple 1 Yes ZONo 1 ☐ Yes 2 ☐ No cartificata of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nasidance 6 Othar (Specify) 1 Yes 2 No 2 this funeral 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Tima of Injury 28c. Injury at Work? Certification: After 1 Attending Division 1 Naturel 5 Pending investigation July 13,99 UNKNO₩N 1 Yes 2 No INHALED PROPANE GAS death. Ne Hospital or Attending 24 hours aftar death
Ne Funeral Director: A plataly filled in by tha f 2 Accident 6 Could not be determined 30 Suicida 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) RESIDENCE 28f. Location (Street and Number of Rutal Route Number City or Town, State) INDIAN HAND 4 ☐ Homicide 18 INDIAN HEAD AVE. MD. 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) Medicai To the Hosp within 24 ho To the Fune complately fi 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. Licanse number 7-16-99 gatie u. Tayouri MD D0050883 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
25500 POINT LOOKOUT RD, Leonard town, MD 20650 31. Dete filed (Month, Dey, Year) 32. Registrer's Signatura State sorts 191999 Registrar JUL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 2 3 7 6 6

re	ath				Certificate of	Death	P.	g. No.	.0700			
		1. Decedent's Neme (First, Mid	ddle, Last)				2. Data of Deat	h	3. Time of Death			
1	Physician	Samuel C	ulbreath, Sr				Month July	10 199				
	/Medical Examiner	4a Facility Name (If not institute	ion, give street and number	Pou+0 23	A approv	4b. City, Town, or Lo		4c. County of De				
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	Funeral	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplaca (Stata or Foreign Country)			
п	Director	249-70-4610	1 □XM 2 □ F	56	rs. Months Days	TIOGIS INIII.	March 1	5, 1943	Saluda, SC			
	p .	Usual Residence of Decedent 10a. Stata 10b. Count	b.	10c. City, Town	or Loopting				10d. Insida City Limits			
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	vith the Ma t or 28a-f a be notified Director	SC Gree	nwood	Greenwo			1 44	On Chinas of lather C				
	With your O	Too. Street and Number			10f. Zip Code		- 1	og. Citizen of What C	ountry?			
	ifter death with the Marylar r items 23s or 2ss-f show that must be notified at Funeral Director	458 96 Highway	12. Was Decedent	Ever in II S	29646	Hispanic Origin? (Sp	acify Ves or No.	U.S.A.	serican Indian			
	Herre Herre Herre	1 Never Merried 2 Me	Armed Forcas	?	13. Was Decedent of If Yes, specify Cub	pan, Mexican, Puerto	Rican, etc.)	Bleck, Wh	ite, atc.			
320	Fr. or	3 ☐ Widowed 4 ☑ Divorce	If Yas Give	140	1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black			
Maryland 21215-0020		15. Decede	ent's Education	16a.	Decedent's Usuel Occu	pation		16b. Kind of Busines	s/Industry			
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pu	ETES 0	17. Fathar's Neme (First, Middle	e, Last)			18. Mother's Nem	e (First, Middle, N	feiden Sumama)				
Vla	should be and Mental marked o umatic av	Eddie Culbreat	th, Sr.			Corine De	ean					
ar	2 sho and is m	19a. Informant's Name/Relation	nship (Type, Print)	19b.	Mailing Addrass (Stree	t and Number or Run	al Routa Number,	City or Town, State,	Zip Code)			
	D = V = D	Connie C. Crav	wford		7 Jesup Ct	., Greenwo	od, SC	29646	- T			
ore	ges 1 an it of Heal if itam 2 or other	20a. Method of Disposition 1 ☑ Burial _2 ☐ Cremation	3 Domoval from State	comoton	Disposition (Name of r, crematory or other pla	ace)	Date 2	20c. Location - City o	r Town, Stata			
E	8 2 4 2	4 Dopation 5 Other			h Baptist	Church Cen	1. 7/15/9	99 Greenw	rood, SC			
Baltimore,	permit. Pa Departmen Important: any injury pncs.	21. Signature of Funeral Service	e Licensee		22. Name end Addr	ass of Facility Joh	nson &	Jenkins, 1	inc.			
Ш	205 2 2	1 (Sreels	S. Unke	us	716 Kenned	y St., NW,	Washing	gton, DC	20011			
	REAL PROPERTY.	23a. Per J. Enter the diseese, shock, or heart teilure. Lis	or complications that cause st only one cause on each i	d the deeth. Do n	ot enter the mode of dy	ing, such es cerdiac	or respiratory erre	est,	Approximate Intervel Between			
	Physician		11	4.5					Onset and Death			
11	/Medical Examiner	Immediata Ceuse (Final diseese or condition	, M.	tile	muchen							
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	Ne Hospital Ne Funeral pletely filled edical Co		ing Physician: To the best									
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	one) Z	and mannar si						Mary ango			
	within 2 To the comple	29b. Signature and title of certifi	ier , / -1.		29c. Licen	ise number	2	9d. Data signed (Mo	ntn, Day, Year)			
		Theody	elle her	Lous	0.	C.M.E.		July 11,	1999			
		30. Name and address of person	n who completed ceuse of		Type, Print)			-				
			EMIKING		enn Street,	Baltimon	e, Maryl	and 21201				
	State	31. Data filed (Month, Dey, Yea	agg 31 Regist	rer's Signeture	Sports							
	Registrar	JOL T. T.	000	10	south.	/						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month July Physician Ollie Cole 1999 5:05AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health of Silver Spring Silver Spring Montgomery | H Under 1 Year | H Under 24 Hrs. | 8. Deta of Birth (Month, Day, Year) | June 28, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 1 F 257-38-2844 69 Georgia Director Usual Rasidance of Dacedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show mast be notified at 1. Yes 2 □ No District of Columbia Director Washington 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 612 - 5th St., N.E. 20002 United States Funeral death fterns 2 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indien, Black, White atc. African filed within 72 hours efter ☐ Yes 2 ☐ No f Yas, Giva A 1 Never Married 2 Merried 21215-0020 9 1 ☐ Yes 2 ☐ No Specify: by Specify. 3 Widowed 4 Divorced American "natural", Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Bus Attendant Government Baltimore, Maryland 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) . Pages 1 end 2 should be filt ment of Health and Mental Hyant: If itsm 27 is marked oth jury or other traumstic aven Be John Nelson Mary Harris 19a. Informant's Name/Relationship (Type, Print)
Regina L. Robinson - Daughter 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 4800 Rodgers Dr., Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or page. Mt. Olivet Cemetery 7/16/99 Wash., D.C. 4 Donation 5 Other (Specify) 21. Signature of Füneral Service Licenses 22. Nama end Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. luda 20019 23a. Part1. Et tar the disease, or complications that caused the disease the mode of dying, such as cardiac or respiratory arrast, shorts, or haer failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in death) Cerebrovascular Accident 7 Days Examiner Dua to (or as a consequence of) Examiner Multiple Sclerosis The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Recurrent Urosepsis Box 68760. physician Physician/Medical the Dua to (or as a consequence of): Sacra Decubiti 080 signed by the at d be detached for Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 Yee 2 No diabetis mellitus Division of Vital Records, Completed by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? hypertension certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attanding Physician: director. 25. Wes casa raferred to medical axaminer? Be 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 410 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Medical Certification: To this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how Injury occurred 28h Time of 28c. Injury at Work? After 1 Natural 5 Pending Invastigation Hospital or Attanding 24 hours after death.
 Funeral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 22164 7-12-99 DC 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) William J. Cullen, M.D. 1011 N. Capitol St., N.E. Wash., D.C.

State Registrar 31. Data filed (Month, Day, Year)

JUL 13 1999

33 Registrer's Signat

33 Registrer's Signature G. Loans

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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KARIN CHAPLES

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	Certificate of Death	Reg. No.	
11	1	2. Data of Death Month Day	3. Tima of Deal

Physician /Medical Examiner

JEANNE 4a Facility Neme (If not institution, giva street and number)

JULY 4b. City, Town, or Location of Death 1999 7:30P.M.

Funeral Director

28a-f show

8

Nerns 23a

Director

Funeral

p

Completed

other traumatic event, the Medical Examiner must be notified at

pemit. Peges 1 and 2 ahould be filed within 72 hours effer d
Department of Health and Mentel Hygiena.
Important: If item 27 is marked other than "natural", or item
eny injury or other traumatic event, the Medical Examples
ands.

Physician /Medical

Examiner

certificate be assecuted physician and the burier-transit

The law requires that the death

or Attending Physician:

this funeral

After

death. Director: A

To the Hospital or Atterwith 24 hours after dea To the Funeral Director completely filled in by the

Box 68760.

P.O.

Division of Vital Records,

Baltimore, Maryland 21215-0020

7954 VANITY FAIR 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10 M 20 F 218-90-4890 36

GREENBELT If Under 24 Hrs. Hours Min. If Under 1 Year Months Days

PRINCE GEORGES 8. Data of Birth (Month, Day, 9. Birthplace (Stata or Foreign Balt.

4c. County of Death

8.

Usual Residence of Decedent 10a Stata 10b. County

1. Decedent's Nama (First, Middle, Last)

10c. City, Town or Location PriNCE GEORGES Greenbelt 10d. Inside City Limits 1 Yas 2 No

10g. Citizen of What Country?

MARY 14ND 10e. Street and Number VANIT

FAIR DrIVE

20770 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.)

U.5A 14. Race - American Indian, Black, Whita, alc.

11. Merital Stalus 1 Never Merried 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No

1 Yas 2 PNo Specify: Specity: WhitE

15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12)

College (1-40r5+)
VASTER'S DEGREE

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) Teacher

Educations

16b. Kind of Businass/Industry

17. Father's Nama (First, Middla, Last)

Alonzo ERNEST Chaples 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)

18. Mother's Nama (First, Middle, Maiden Sumeme)

HARDEI essecua

Powhat AN 5422 20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale PK 20c. Location - City or Town, State

20a. Method of Disposition 1 Burial 2 Comation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

HESA PEAKE

BELTSVILLE 199

21. Signature of Funeral Service Ligense

23a. Pert I. Entar V. disea shock, or he rt feilure disea

22. Nama and Addrass of Facility SERVICE TERUNG FUNGRAL

CREM

Immediata Causa (Final disease or condition resulting in death)

Dua to (or as a consequence of)

Approximate Interval Between Onset and Death boembolus com

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Dua of (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

edema

24a. Was an autopsy performed?

1 DYas

26. Place of Death (Check only ona)

24b. Ware autopsy findings available prior to completion of cause of death? 2 No

25. Was casa referred to medical axaminer? 1⊠ Yes 2 No

Hospitel: 28a. Dete of Injury (Month, Day Year)

1 | Inpatiant 2 | ER/Outpatient 3 | DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Nesidence 8 Other (Specify) 28d. Describe how injury occurred

2 No

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 8 Could not be detarmined

1 ☐ Yas 2 ☐ No 28a. Place of Injury - At home, ferm, street, fectory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

JULY 9, 1999

29d. Data signed (Month, Day, Year)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

Completed by

8

edical Certification: To

son who completed causa of death (Item 23a) (Type, Print) 30. Nama and addras s of p

111 Penn Street, Baltimore, Maryland 21201

0 Day, Year) 31. Data filed (Month,

JUL

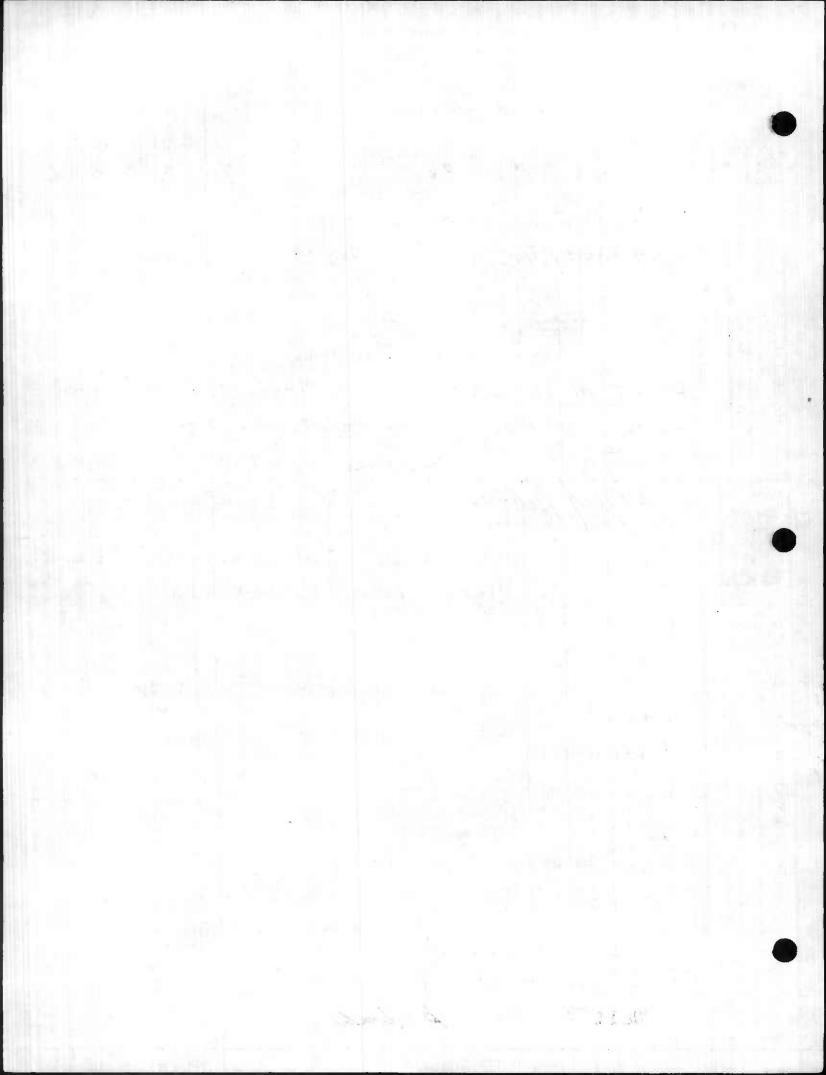
1 5 1999

29b. Signature and title of certifier

estaner 32. Registrar's Signetura

State Registrar

DHMH 16 Rev 6/95



Please 7	ype or Print in B State of Maryland	d / Depar	tment of	Health an				23769		
4.5		Ceni	ificate of	Death	1	Reg. No.		1		
1. Decedent's Neme (First, Middle, Last)						eeth Dey	Yeer	3. Tima of Death		
John Nelso					July		999	9:10pm		
4e. Facility Neme (If not institution, give s	street end number)			4b. City, Town	, or Location of Dee	th 4c. Count	y of Death			
Sociei Security Number 6. Sex			ff Under 1 Yee Months Dey			irth ey, Year)		eorge's Co lece (State or Foreign otry)		
Usuel Residence of Decadant					, , , , , ,		1101			
Maryland Prince Ge		Town or Loca	ition				1	0d. Inside City Limits XXYes 2 No		
10e. Street end Number 13003 9th Street	<u> </u>		10f. Zip Code	207	19	10g. Citizen of United				
11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Never Merried 1 ☑ Never Merried 1 ☑ Yes 2 ☐ No If Yes, Give			13. Wes Decedent of Hispenic Origin? (Specify Yes or No if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 ☐ Yes 2 ☑ No Specify:				The second secon			
3 ☐ Widowed 4 ☐ Divorced	Yeer or Dates: WWII		1 1 62	Specify:		Specii	Specify: White			
15. Decedent's Educ (Specify only highest grede	15. Decedent's Education (Specify only highest grade completed) ary/Secondary (0-12) 16e. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired)						16b. Kind of Business/Industry			
8 0		Machin	ne Oper	ator		Construction				
17. Fether's Neme (First, Middle, Last)				18. Mother's	Name (First, Middle	e, Meiden Sumer	ne)			
George Conway				Man	rgaret Do	nnelly				
19a. Informant's Name/Relationship (Tyr. Kenneth T. Conway				ster Lai	r Aurel Route Numb	ber, City or Town		Code) 0715		
20a. Method of Disposition 10☐48urial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State		ion (Neme of tory or other pi	-	16, Deta 199	20c. Location	- City or To	wn, Stete		
23e. Perri. Enter the disease, or complications, or heart feiture. List only on immediate Ceuse (Fine) disease or condition rasulting in deeth)	A CUTE Dua to (or a Right	Do not enter	SPITOI	ring, such es car	Rd. Bowler diec or respiretory of LIVRE	errest,	nd 20	Approximate Intervel Between Onset and Death 1-2 dms Few days.		
Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disaese or injury that initieted avents resulting in deeth) Lest	altred	4	Not,	stollins				weelig		
Pert ii. Other significant conditions cont	oributing to death but not result	ing in the under	erlying cause o	iven in Pert i.		tobacco use co	ontribute to	the cause of death?		
Cowing arting disease					24e. Wes	s en eutopsy ormed?	24b. Were autopsy findings aveileble prior to completion of ceuse of death?			
Serizonale distrolla					10	Yes 2X No				
25. Was case referred to medical examiner?	oenital:				Death (Check only	one)				
27. Manner of Death		R/Outpatient 28b. Time of	3□ DOA O 28c. Inj		ng Home 5 🗆 Res 28d. Describe	idence 8 Oth		γ)		
1 Neturel 5 Panding 2 Accident investigation 3 Suicide Could not be determined	(Month, Dey Year) Injury Work? M 1 ☐ Yes 2 ☐ No 28a. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify)				28f. Location (Street end Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 Z Certifying Physic (Check only one) 2 Medical Examination	lcian: To the best of my knowlear: On the basis of examinetion end menner steted.	edga, death or on end/or inves	ccurred et the stigation, in my	time, dete end p opinion, deeth o	iece, end due to the occurred et the time	ceuse(s) end m , dete end plece,	annar as st	lated. tha causa(s)		
29b. Signature and title of dertifier	and manner steled.		29n Lines	nse number		29d. Date signe	ad (Month	Day Year)		
Acha and the order the	mD			\$341\		July	13 ,	1999		
30. Neme end eddress of person who con	nplated cause of deeth (item 2		int) Ramie		M D	2171/				

32. Registrer's Signetura

State Registrar 31. Dete filed (Month, Dey, Year)

JUL 1 6 1999

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ferm 27 is marked other than "natural", or ferms 23a or 28a-f show any injury or other traumatic event, or a Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be associated within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and complished in by the funeral director, page 2 should be deteched for use as the bunkl-transit complished in by the funeral director, page 2 should be deteched for use as the bunkl-transit

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

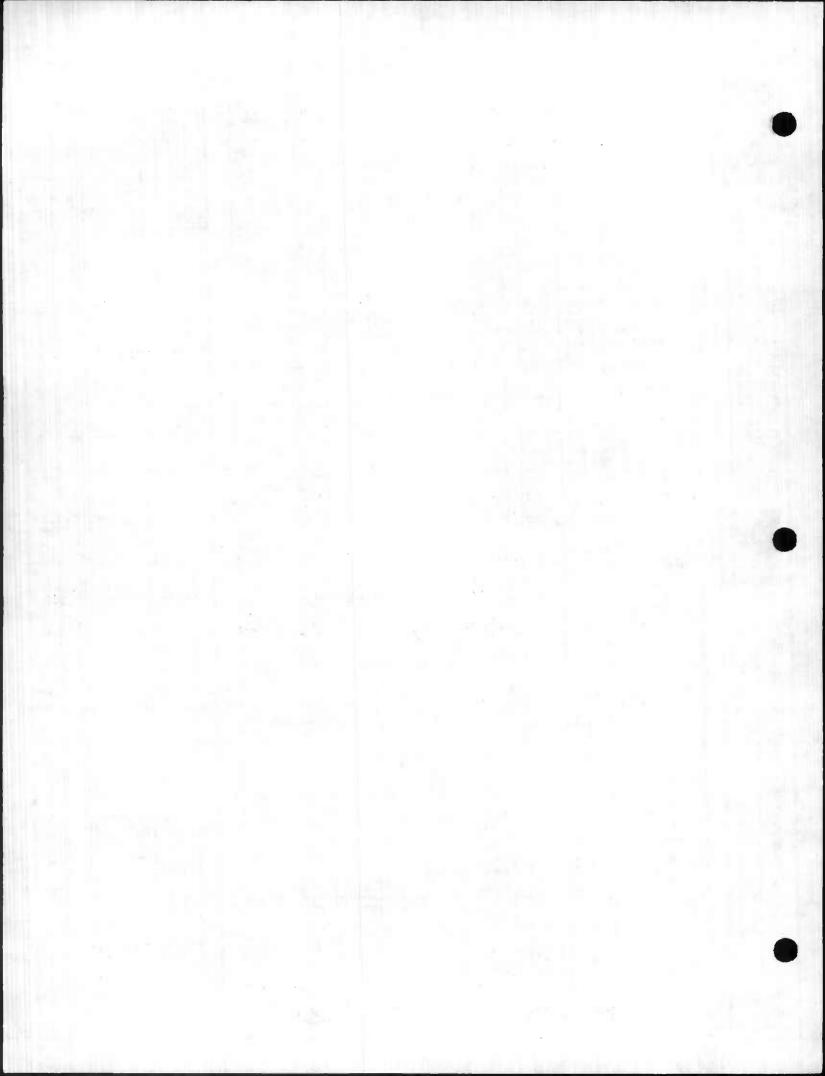
NELDOM Conway

Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 23770

			Cer	tificate of	Death		Reg. No.				
	1. Decedent's Nama (First, Middle, Last)		-			2. Date of De Month		Year	3. Time of Death		
Physician	Theodore Eugene	Crouse				JULY 7	. 1999	rear	0400		
/Medical	4a Facility Nama (If not institution, giva str				4b. City, Town	n, or Location of Deat		ty of Death			
Examiner					Combos	al au d					
	Sacred Heart Hosp: 5. Social Security Number 6. Sex	7. Age (tn yrs. le	n na h-Inda ida . sk	If Under 1 Year	Cumber 24		ALI	egany			
neral	157 4	7. Age (tn yrs. 164	Yrs.	Months Days		Min. (Month, D.	y, Year)	9. Birthpia	ace (State or Foreign try)		
ector	217-30-1672	TIS.			06 17-1	06 17-1935 Md					
	Usual Residence of Decedent	140- 60-	Town sale					Tar			
by Funeral Director	10a. Stata 10b. County		, Town or Lo	Callon				10	Od. Inside City Limits		
5	Md Garrett	Vak	cland				1 ☑ Yes 2 ☐ No				
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	try?		
0	121 E. Oak St			2155	0		USA				
678		. Was Decedent Ever in U.S	13 1			n? (Specify Ves or N					
Funeral	The state of the s	Armed Forces?	d Forces? If Yes, specify Cut			Puerto Rican, etc.)	Black, White, etc.				
by F	1 Never Married 28 Merried	1 Nes 2 No If Yes, Give	ive		Specify:		Spec	Specify:			
	3 Widowed 4 Divorced	Yeer or Detes: 1953					White				
Completed	15. Decedent's Educa (Specify only highest grada of		16a. Deced	ient's Usual Occu kind of work done	pation during most o	of working	16b. Kind of	Business/Ind	lustry		
9	Elementary/Secondary (0-12)	College (1-4or 5+)	tife. L	OO NOT use retire	ed)		700				
0	11		Painter				Comercial Painting				
	17. Fathar's Name (First, Middla, Last)		16. Mother's Name (First, M				iddle, Maiden Sumame)				
Be C	John Crouse		Döllie Eckar				a				
2		- D. (- d)	400 14-70								
	19e. Informent's Neme/Relationship (Type	, Print)				or Rural Route Numb		i, State, Zip	Code)		
	Doris Crouse		121	E. Oak S	t Oak.	land, Md 2	nd,Md 21550				
	20e. Method of Disposition	0.0	ace of Dispo	sition (Name of netory or other pla	ace)	Date	20c. Location	- City or Toy	wn, Stata		
	1 Burial 2 Cremetion 3 Ren	novel from State	motory, crom	notory or outer pre	500)	1					
	4 Donetion 5 Other (Specify)	Kalh	augh (Cemetery . Neme end Addr		07 09 99	Elk Ga	rden V	V.Va		
	21. Signature of Euneral Service Licensee	0									
a	Marin 11	Sundack	7	David A.	burdo	ж ғн Kitzmille	. M.J. O	1550			
	23a. P. 1. Entar tha disease, or complica	itions that caused the deeth	. Do not ente	er the mode of dy	ing, such as ca	ardiac or respiratory a	rrest,	1550_	Approximate		
	shock, or heart feilure. List only one	cause on each line.							Onset and Death		
n al	Immediate Course (Final	ANDVE		11111	DINAL	PARIL			-1		
	Immediate Cause (Final disease or condition	MINUXIC		ENCE	HALU	PATHY.		!	Sday		
1	resulting In deeth) a	, Due to (or	as a conseq	uence of);	p			8 1			
Examiner		1/entricula	w fi	prilla Ti	20				5 days		
Ē	b. Verifficação o 1997										
X									-1		
									Sday		
Medical	thet initiated events rasulting in death) Last Due to (or as a consequence of):							İ	/		
X		Arten	n December				1021				
2	6	Corono	1	my,					1		
Physician	Part II. Other significant conditions contri	buting to death but not resur	Iting in the u	nderlying cause o	iven in Part I	23b. Did	tobacco use c	ontribute to	the cause of death		
Ş	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in F					200.010					
	Mario c Kenal	(OPD) Hy he Kalenia				Probably 4 Unkn					
been signed by the atte should be detached for leted by Physicia		9/1/			-		T 045 1W-	an and an and disable an			
					a. Was an autopsy performed? 24b. Were autopsy fit available prior to available prior to available prior to						
ple					-			mpletion of cause death?			
s certificate has been s director, page 2 should To Be Completed							Vac alla	1.5	Yes 2 No		
						10	Yes 2 No		1 168 ZLJ NO		
	25. Wes case refarred to medical axaminar?	100				of Daeth (Check only	one)				
.0	1 ☐ Yes 2 🔀 No Hos	spital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing				ing Home 5 Res	Home 5 ☐ Residence 6 ☐ Other (Specify)				
To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	27. Mannar of Death	1	28b. Time of	28c. Inju	ury at	28d. Describe	28d. Describe how injury occurred				
	1 90,1010101	(Month, Day Year)	ır) İnjury Work? M 1☐ Yes 2☐ No			0					
20	3 Suicide 6 ☐ Could not be				28f Location	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ŧ	4 Homicide determined										
ပ္											
<u>a</u>		lan: To the best of my know									
edical	(Check only 2 Medical Examiner one)	 r: On the basis of examination and manner stated. 	on and/or inv	restigation, in my	opinion, death	occurred at the time	, date and place	, and due to	the cause(s)		
X	29b. Signatura and titla of certifier	0		29c. Licen	se number		29d. Data sigr	ed (Month, I	Day, Year)		
	1/ /	1071	1 G. off								
	N-17-10	M/s/M			1751	8	JULY 8	74, 19	999		
	30. Name and address of person-who com	pleted cause of death (Item	23a) (Type,	Print)	-	0	, .				
	Nagacotoon Kons	Than MD	5171	SIdtNin	Road	Cumber	land)	4D à	21502		
24-4	31. Date filed (Month, Dey, Year)	32. Registrar's Signati	ure				G COV				
State	11 Date med (Month, Dey, rear)	30	, 6			1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

				Cei	rtificate of	Death		Reg. No.	Total	0111		
	Physician	Decedent's Name (First, Middla, Palmira M. Cue	Last)				2. Dete of Do		Year	3. Time of Deeth 9:20 AM		
	/Medical	4a Facility Nama (If not institution,	ain attact and number			Ah City Town	or Location of Dear		of Death	9.20 AT		
)	Examiner	Moran Manor Heal										
			6. Sex 7. Age (In yrs. I	het hirthday)	If Undar 1 Year	Western	-	Alle	-	place (State or Foreign		
н	Funeral	212-74-6954	1□M 2√F 92	Yrs.	Montha Deys		lin. (Month, Di	ey, Year)		olece (Stata or Foreign ntry)		
	Director	Usual Residence of Decedant) 25				11/22/	06	Sp	pain		
	and and	10a. Stete 10b. County	10c. City	y, Town or Lo	ocation				1	10d. Inside City Limits		
	fahr ed a	Md Allega	any	Luke						1X Yes 2 No		
	the 1	10e. Street and Number	_		10f. Zip Coda			10g. Citizen of V	Whet Cour	ntry?		
	with with	337 Fairview S	Street		21540)		United		·		
	sath sath	11. Meritai Stetus	12. Was Decedent Ever in U,	S 13 1			(Specify Yes or N			can Indien.		
	urs after death with the Mai at', or items 23s or 25s-f si anticermit to nutries by Funeral Director	1 Naver Merried 2 Marrie	Armed Forces?		If Yes, specify Cub	oan, Maxican, P	uerto Rican, etc.)		ck, White,			
20	f. or	3. Widowed 4 □ Divorced	If Yes, Give		Yes 2□No	Specify: S	panish	Specify	/: Wh	nite		
21215-0020	filed within 72 hours after death with the Maryland thygiene. Applied a "natural", or items 23s or 28s-f show and, the Medical Examinar must be multiled at a Completed by Funeral Director.	15. Decedent's		16a. Dece	dent's Usuel Occu	pation		16b. Kind of B	usinass/In	dustry		
215	be filed within 72 hor tei Hygiene. d other than "natura avent, the Medical Be Completed	(Specify only highest Elementery/Secondary (0-12)	grade complated) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of ed)	working					
21	jene r the	Unknown	College (1-401 ST)	Hom	memaker			Home				
פ	office of the of	17. Fathar's Name (First, Middle, L.	ast)			18. Mother's	Neme (First, Middle		1a)			
lai	Mente arked atic e	Fernando Prado				Carm	Carmine Rodriguez					
Maryland	shoot shoot and h	19a. Informant's Neme/Reletionshi	p (Type, Print)	19b. Meili	ng Address (Stree	t and Number o	r Rural Route Numb	Code)				
	aith 27 la	Lee Ann Cueva /	rt, MD 21562									
re	of He other	Lee Ann Cueva / Granddaughter 420 Maryland Ave. Westernport, MD 21562 20a. Method of Disposition 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Tow										
E	Page ent c mt: If	4 □ Donetlon 5 □ Other (Spe	nport	. MD								
altimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentei Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 23s-f show any injury or other traumatic event, the Medical Examinar man be notified at once. To Be Completed by Funeral Director	21. Signeture of Funerei Service L			er's Cem 2. Nama and Addr		7/6/99	111 Chu				
m	Deper Impo	Frankl. Y		P	oal Fune	ral Hom		Western				
		23a. Pert1. Enter the disease, or c	omplications that caused the death				-		OLU,	Approximate		
Ш	Physician	shock, or heart fellure. List o	nly one ceuse on each line.						į	Interval Between Onset and Death		
\mathcal{C}	/Medical	Immediate Cause (Final	aut	1/1	111110	c - 0	21	T.	1	3000		
	Examiner	diseese or condition resulting in deeth)	6.	r es e consec	nuonca off:	rdial	Inja	reun		30mines		
			500 10 10	1 03 0 0011300	qualito oi).				-			
	eath certificate be assouted attending physician and for use as the bunel-transit clar/Medical Examiner	Sequentially list conditions,	b Dua to (o									
ó	axec an an riel-tr	if eny, leading to immediate cause. Enter Underlying							į			
68760,	ysicii ve bu	Ceuse (Diseese or Injury that initiated events	c Due to (or	r es a conseq	quence of):				-			
	uffice as th	resulting in death) Last							1			
XO	0 0 5 5		d									
œ.	The iaw requires that the death cate has been signed by the attendage 2 should be detached for uspage 2.	Pert II. Other eignificant condition	e contributing to death but not res	uiting in the u	inderlying cause gi	iven in Part I.	23b. Did	I tobacco uae co	ntribute to	to the cause of death?		
P. O.	by the stackh	1 Domina	anten !	Disea	6	7-15	. 10	Yee 2□ No	3 Pro	bably **Unknown		
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ord	v require been si should leted		le tus					s an eutopsy lomed?	av	Pere eutopsy findings vailable prior to		
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	sician: The law requir certificate has been s director, page 2 should o Be Completed						10	Yas 2 No	1[☐ Yes XXNo		
ita		25. Was case referred to medical				28. Placa of	Deeth (Check only	one)	1			
>	> 0 0 L	exeminar? 1 ☐ Yes 2000No	Hospitel: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	ther: 4K Nursir	ng Home 5 ☐ Res	idenca 8 🗆 Oth	ner (Specil	(ty)		
Division of Vital	er this neral di	27. Menner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju	ary at	28d. Describe	how Injury occur	red			
0	Attending or death. ector: After fune by the fune lification:	1 Seture 5 Pending 2 Accident investige	ation	v.,y]Yes 2□No						
<u> </u>	Afte or de by the by the tiffic	3 Sulcide 6 Could no determin	of be ned 28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	reat, fectory, offica			(Street and Numb own, State)	ber or Run	ral Routa Number,		
	s after al Directify		saliding, old (open)	,,								
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	(Check only 2 Medical E	Phyeician: To the best of my know xaminer: On the basis of axeminer									
	within 2 within 2 To the F complete	one)	and manner stated.			nsa number		29d. Dete signe				
	C T V C	29b. Signature and title of certifiar						-				
		17/1	<i>)</i> /.		7	1212-	++	July	- 1	1999		
		30. Neme end eddress of person w										
			M.D. Frostb		aza, Fro	ostburg	, MD 215	32				
	State Registrar	31. Date filed (Month, Dey, Year)	32. Registrer's Signe	iture _	Soo	all I						
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0730 Susie Coates July /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Yrs. 78 Alabama Director 264-34-3356 with the Manyland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Experies must be notified at 1 ☐ Yes 2 ☐ No Directo MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 27454 Edgewood Circle 21801 U.S. Funeral death 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus filed within 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married Black 1 ☐ Yes 2X No p 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Department of Health and Mentel Hygiene. Important: if Item 27 ie marked other than " Elementery/Secondary (0-12) College (1-4or 5+) 9th Poultry Line worker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Parks Duke Granger 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Broderick Mitchell/son 27454 Edgewood Circle, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from Stete any injury c 4 ☐ Donetion 5 ☐ Other (Specify) Springhill Memory Gardens 7/9/99 Salisbury, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home 21. Signature of Funeral Service Licensee 1618 West Rd., Salisbury, MD 21801 23a. Paux. Enter the study e, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or bent failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medicai Respiration Hypercubic Examiner Physician/Medical Examiner Cerebral Hemourh The law requires that the death certificate be executed ettending physician and for use es the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Susie Contes 264-34-3356 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown signed by Paronymul Amel Fibrillan þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed Deed ty pertonsion has L 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral directors. 27. Menner of Death 28b. Time of tnjury 28d. Describe how injury occurred Certification: 28c. tnjury et Work? or Attending 1 Netural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Cartifier 2 Medical Examinar: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0050614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Penburan Dr. Suti 24, Solisbury Md 2180)

State Registrar JARRAH

JUL 0 8 1999

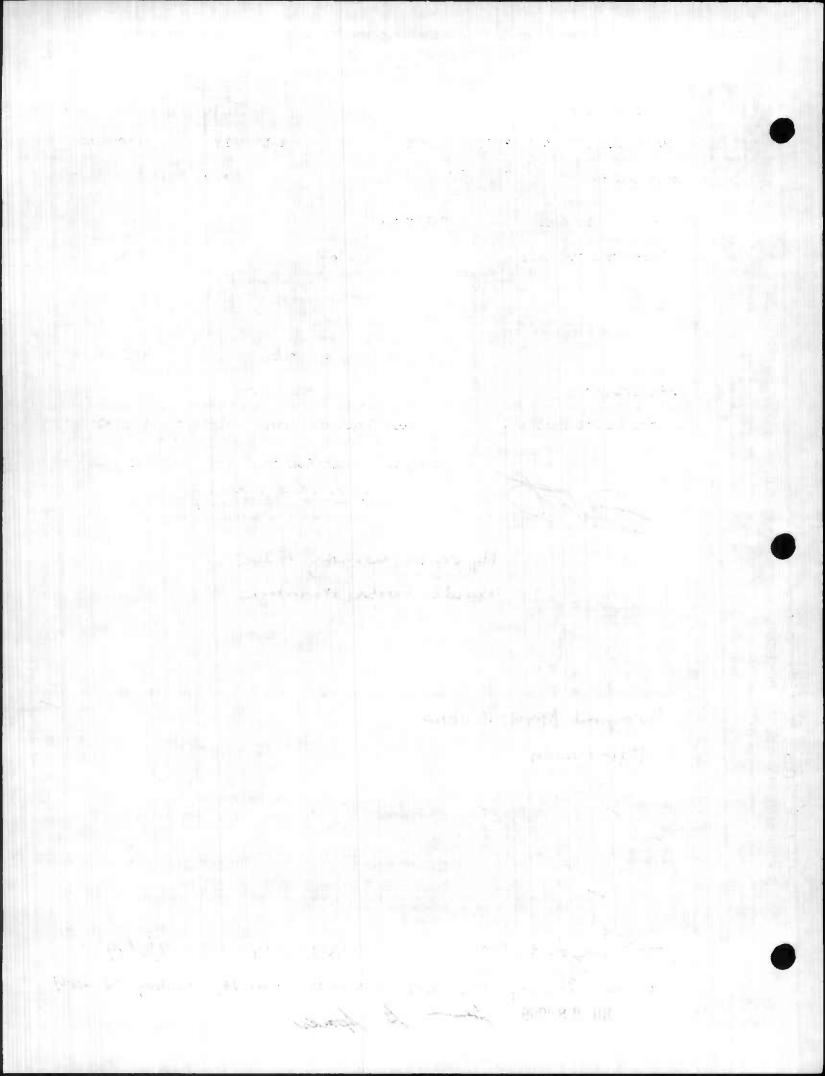
MD

32. Registrar's Signature

1201

Lorraine

31. Date filed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Thomas Church July 2, 1999 7:55 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Center: Genesis ElderCare Salisbury, Wicomico MD 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 12 M 2 F Months Days Hours 83 213-14-7405 February 24, 1916 North Carolina Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Wicomico 1 Yas 2 No Director Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Bridge Street 21837 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. 1 XYes 2 No
If Yes, Give
Year or Detes: WW II 1 Never Married 2 Merried 1 ☐ Yes 2X No Specify: Specify: White P 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Manufacturing Foreman 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John V. Church Sallie E. McNeil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys N. Banks/Sister 104 Chestnut St., Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/7/99 Hebron, MD Springhill Memory Gardens 4 ☐ Donation S ☐ Other (\$pecify) 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility Holloway Funeral Home Professional Association Wur 501 Snow Hill Rd., Salisbury, MD 21804 m. Enter it seese, it complications that caused the rick, or heart failure. List only one cause on each line. eeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximate Interval Between Onset and Death Immedieta Cause (Final 700 disaese or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

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Director:

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Medical Certification: To

P.O. Box 68760.

Records,

Division of Vitai or Attending Physician: **Funeral**

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after (
Department of Health and Mental Hygiene.
Important: If them 27 Is marked other than "natural", or han
any injury or other traumatic avent, the Heddell Enterna

Baltimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical þ Completed

Dua to (or es a consequence of): Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 22No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work?

28e. Dete of Injury (Month, Dey Year) 5 Pending Netural 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12108 2 No

3 Probably 4 Unknown

padl 5+1 VA

State Registrar 31. Dete filed (Month, Day, Year) JUL 0 8 1999 32. Registrer's Signature

ML 0 8 1995 Somme & of the series

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health a		
Certificate of Death	Reg. No.	20115
ast)	2. Date of Death	3. Tima of Death

	Decedent's Neme (First, Middle, Li	nst)		ertificate	, UI L	Dealli	Reg 2. Date of Death	. No.	3 Tin	na ot Death			
ysician				I DOTTO			Month	Dey	Year				
Medical	WILLIAM 4a Facility Name (If not institution, gir	MICHAEL ve street and number)		ARTER_	4	b. City, Town, or Lo	July 01 cation of Death	4c. County)5 A.M			
aminer													
	299 B Locust Tex 5. Social Security Number 6.		yrs. last birthda	If Under 1		Salisbury If Under 24 Hrs.			OMICO 9 Birtholece (St	ate or Forei			
eral : ctor		1₩ 2□F	Yrs.	Months	Deys	Hours Min.	8. Dete of Birth (Month, Day, Y		9. Birthplace (St Country)				
	Usual Residence of Decedent	47				1 1	January 1,	1952	Marylan	a			
H	10a, State 10b. County	10	c. City, Town or	Location					10d. Insk	de City Limit			
rector	Maryland Wicom	ico	Sali	sbury					1 🔀 Yes 2 🗆				
Director	10e. Street and Number			10f. Zip (Code		100	. Citizen of V	What Country?				
A 0	299 B Locust Te	rrace		21	801			USA					
Funeral	11. Meritel Stetus	12. Wes Decedent Ever	r in U,S. 13			ispanic Origin? (Spe in, Mexican, Puerto I	city Yes or No-	14. Rec	a - American Indie	n,			
Ē	1 Never Merried 2 Merried	Armed Forces? 1 No 2 No .					Rican, etc.)	Bled	ck, White, etc.				
by Funer	3 Widowed 4 Divorced	If Yes, Give	Army- Navy	1 ☐ Yes 2	No No	Specify:		. White					
3	15. Decedent's E	ducation		cedent's Usuel	Occupa	ation	16	b. Kind of Bu	usiness/Industry				
Be Completed	(Specify only highest gr. Elementery/Secondary (0-12)	ade completed) College (1-4or 5+)	(Gi	o. DO NOT use	one d retired,	ation during most of workir i)							
E	12	—	F	armer				lture					
9	17. Father's Neme (First, Middle, Last)				18. Mother's Name	(First, Middle, Me	iden Sumen	10)				
ToB	William Harry C	arter				Margare	t		Slaught	er			
-	19a. Intorment's Neme/Reletionship	(Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, 2										
To Be C	William H. Carte	r/Father	60	3E Rive	rsi	de Dr. S	alishurv	MD 2	1801				
any Injury or other once.	20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, crametory or other place) 20c. Location - City or Town, State												
	1 Description 1 Description 1 Removed from State 4 Donation 5 Other (ppecify) Wicomico Memorial Park 7/6/99 Salisbury, MD												
	21. Signeture of Funeral Service Lice			22. Neme end		-d &	10133		out, in				
	21. Signeture of Furierer Service Lice	10/1/				uneral Ho	me Profe	ssiona	l Associ	ation			
	X4 201.	4KM OTES		501 Snc	W H	ill Rd.	Salisbur	y, MD					
	23a Part1. Enter the disease, or conships, or heart feilure. List only	plications that caused the one ceuse on each line.	death po not e	enter the mode	of dying	g, such as cardiac o	r respiretory arres	t,	Approx	Between			
an al		111	//			,		,		and Deeth			
	Immediate Cause (Finel disease or condition resulting in death)	dis	ease										
	resulting in demin)	Due	to (or es a cons										
Examiner		b							1				
Cam	Sequentially list conditions,	Due	to (or as a cons	to (or as a consequence of):									
<u> </u>	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	C											
dical Examir	that initiated events resulting In death) Last	Due	to (or es e cons	equence of):									
		4											
leted by Physician/Me		U.								1			
Physician/M	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying ca	use give	en in Pert I.	23b. Dld tob	ecco usa co	ntributa to the ca	use of deat			
Phy							19 Yea	2□ No	3 Probably	4 🗆 Unkno			
by													
8	390 111						24a. Was an parforme		24b. Were auto available p	psy findings prior to			
olet							parronne		completion of death?	n of cause			
Completed							107/4	2 🗆 No	1 Pres	2 No			
						26 Place of Death							
Physician: The faw this certificate has to ral director, page 2 s. TO Be Compli.	25 Was case referred to medical			26. Place of Death (Check only one)									
Ď.	25. Was case referred to medical examiner?	Hospital:	2[] ED/O-1	iont all no.	Othe								
2	25. Was case referred to medical examiner? YE Yes 2 No 27. Menner of Death	1 □ Inpatient	2 ER/Outpati		A	4 LI Nursing Hor	ne 5 Residen						
10	examiner? 10 Yes 2 No 27. Menner of Death 10 Netural 5 Pending	28e. Date of Injury (Month, Dey Ye			sc. Injury Work	4 LI Nursing Hor							
y ure turneral orrect fication: To Be	examiner? YE Yes 2 No 27. Menner of Death 1 Menural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Date of Injury (Month, Dey Ye	28b. Time Injury	of 28	Sc. Injury Work	y at k? Yes 2 No	28d. Describe how	Injury occur	red	Number,			
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Hospital or Attanding Physician: The law requires that the death certific after death. Director: Af filled in by 24 hours a To the P within 2

Medical Certification: To

HHIVA

Registrar

State

29b. Signature and title of certilier

29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mapper stated.

O.C.M.E.

29d. Date signed (Month, Day, Year) July 02, 1999

23b. Did tobacco usa contributa to the cause of death?

19Yea 2 No 3 Probably 4 Unknown

8:05 A.M.

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 XYes 2 No

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Fowler

8 1999

32. Begistrar's Signeture

111 Penn Street, Baltimore, Maryland 21201

Sports

from the species

100 8 1993

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 23775

			Cer	tificate of	Death		Reg. No.	20110			
	1. Decedent's Name (First, Middle, L.	nst)				2. Data of Dea	nth	3. Time of Death			
Physician	Bessie Ann	ia Cani	twell			Month		Year C-FORM			
/Medical	4a Facility Name (If not institution, gi		CMCII		4b. City, Town, or	July Location of Death	11, 199 4c. County o				
Examiner	Salisbury Cente		awcDava6								
			s. last birthday)	If Under 1 Year		iry, Md.	Wicomi				
Funeral Director		1□ M 280 F 84	Yrs.	Months Days		8. Date of Birth (Month, Day November	13,1914	9. Birthplace (State or Foreig Country) Virginia			
Pur A	10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits			
vith the Mery or 28a-f ehc be notified	Maryland Wicon	nico S	alisbur	У	No. of Co.			12⊈ Yes 2□ No			
death with the Meryland ms 23s or 28s-f show create be notified at neral Director	1408 Emerson A	Ave.		10f. Zip Code 218	301		10g. Citizen of WI USA	nat Country?			
dead dead	11. Marital Status	12. Was Decedent Ever in	U,S. 13. V		Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No-		- American Indian,			
d 2 should be filled within 72 hours after death with the Marylan his and Mental Hyglene. 7 is marked other than "natural", or items 23s or 28s-f show treumstic avant, the Medical Examiner must be notified at treumstic avant, the Medical Examiner must be notified at To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Tes, specify Cul		no Hican, etc.)	Specify:	, White, etc. White			
Por string	15. Decedent's E	ducation	16a, Deced	lent's Usual Occu	petion		16b. Kind of Bus	d of Business/Industry			
in 72	(Specify only highest gr	ade completed)	(Give		during most of wo	orking		Head State			
With the same	Elementary/Secondary (0-12)	College (1-4or 5+)		retary			Hospita				
be filed within 72 housely last Hygiene. I other then "natural yeart, the Medical Be Completed	17. Father's Name (First, Middle, Las)	360	rccary	18. Mother's No	Name (First, Middle, Maiden Surname)					
Be Be	George Wescott	•									
should ind Mening Inserted umartical		-		a Addison Smith or or Rural Route Number, City or Town, State, Zip Code)							
2 sh and I e m	19a. Informant's Name/Relationship				State, Zip Code)						
	Arthur B. Cantwe	y MD 21801									
20 20	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	cemetery, cren	sition (Name of natory or other pl Cemeter		7/16/99		sbury, MD			
pemit. Page Department Important: if any injury or once.	21. Signature of Funeral Service Lice			. Name and Addi							
99 E # 8	23a. Part1. Enter the disease, or con shock, or heart tailure. List only	Dompoon plications that clused the de- one cause on each line.		501 Snow	Hill Rd	Salish	oury. MD	Approximate Interval Between			
Physician /Medical	Immediate Cause (Final disease or condition	Bu			,			Onset and Death			
Examiner	resulting in death)		(or as a conseq					1 7			
ě		al lin		-0-	- /						
Par E	Sequentially tiet conditions	b. Due to	(or as a conseq	neuce og.	3000			got.			
physician and the buriel-transit edical Examiner	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
7 P S	resulting in death) Last	d.	(or as a consequ	uence of):							
esth ce stendir for usa clan/h											
	Part It. Other significant conditions	contributing to death but not re	sulting in the ur	nderlying cause g	iven in Part I.	23b. Did t	obecco use cont	tribute to the cause of death			
res that the death ce igned by the ettendi be deteched for use by Physician/I						10	res 2 No	3 Probably 4 d Unknow			
been a should							an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?			
Physician: The law this certificate has ral director, page 2 : To Be Comp						101	res 212 No	1□Yes 2⊟No			
or. p	25. Wes case referred to medical				26 Diago of D						
Physician: this certific ral director,	examiner?	Hospital:	Jene		thor	eath (Check only o		1041			
this aldi	1 Yes 2 No	1 □ Inpatient 2	ER/Outpetien 28b. Time of	1 3LI DOA	4 Mursing	Home 5 ☐ Resid	lence 8 GOther now injury occurre				
Attanding Phy or death. ector: After thi by the funeral iffication: T	1 Natural 5 Pending 2 Accident investigation		Injury	W	ork? ☐ Yes 2 ☐ No	200. Describe (low injury occurre				
685c TI	3 Suicide 6 Could not lead to determine determined		home, tarm, stre city)	eet, tactory, office		28f. Location (S City or Tox		r or Rural Route Number,			
To the Hospital o within 24 hours of To the Funeral Di completely filled is Medical Cel	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the trestigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and man date and place, a	ner as stated. nd due to the cause(s)			
M M	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed	(Month, Day, Year)			
->-0	1 man		7/-	100							
	- / //	7		D-29	,543		1/12/	77			
8	30. Name and address of person who		, , , , ,				/ /				
X	WILLIAM ROBINS	M.D.,1104 HE	CALTHWAY	DR., SAI	ISBURY,	MD. 218	04				
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign		1		210					

DHMH 16 Rev 6/95

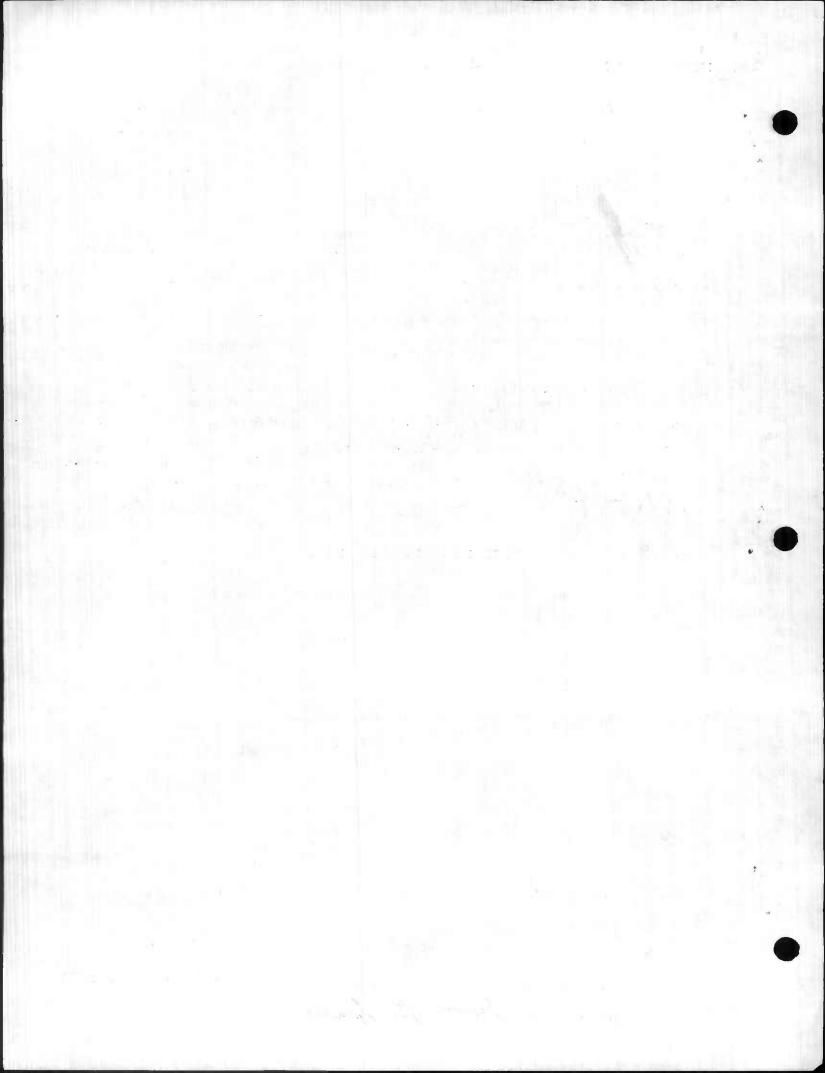
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	2D		MS: #23 PART I, 27 PER						d Mental Hy	rgiene Reg. No.	9 23	3776		
	Physicia	ın	Decedent's Neme (First, Middle, Las	t)					2. Date of Do Month	eath Day	Year 3	3. Tima of Death		
	/Medic	-		Baird Cor	1ett				JULY	12 199		0045		
	Éxamin	er	4e Facility Name (If not institution, give						, or Location of Deal	,				
			6307 STATUM RI 5. Sccial Security Number 6. Se		. An ion for	në formbular d	If Under 1 Year	PRESTO		CARO		a /Ctata as Casaina		
l.	⊮Funeral Director			0X 7. Age	6 (In yrs. la:	14.1	Months Days		Min. (Month, D.	16, 1943		e (State or Foreign) ylvania		
	yland man		10a. Stete 10b. County		10c. City,	Town or Lo	cation				10d.	Inside City Limits		
	Mar	tor	Maryland Carolin	ne	Pr	eston						1 ☐ Yes 2 No		
	h with the 23a or 28 at 5a no	Funeral Director	10e. Street and Number 6307 Statum Road				10f. Zip Code 21655	5		10g. Citizen of V United				
21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f ahow ent, the Medical Examinar must be notified at	by Funer	11. Meritel Status 1 ☑ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 112 Yes 2 114 Yes, Give V Year or Dates:	ver in U.S. 1 etna 1 970	13. Y	Nas Decedent of Yes, specify Cul I ☐ Yes 2 ☑ No	ban, Mexican, F	7 (Specify Yes or Noverto Rican, etc.)	Blac Specify	e - American ck, White, etc. /: Casian			
P	"natural".	P	15. Decedent's Ed	JCation	13.0	TOU. DECEC	lent's Usual Occu	pation	f delin n	16b. Kind of B				
2	within 7 ene. then "n	Be Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	kind of work done OO NOT use retin	ed)	working					
	filed wi Hygien ther th	000	12 HS Grad.			Elect	ronic Re	_		Busines		ines		
	0 = 0 5		17. Father's Neme (First, Middle, Last)					18. Mother's	Neme (First, Middle	, Meiden Surnan	10)			
2	Mer Mer	2												
Maryland	2 2 2 2		9a. Informant's Name/Relationship (Type, Print) Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	s 1 and f Haalth them 27 other to	-	Earl Towers 20a. Method of Disposition	Represent			NOTTIL I sition (Name of	Bradford	Date	Searora 20c. Location -				
Ö	0 0 - 2	- 1	12 Burial 2 ☐ Cremation 3 ☐		MD con	aster	n'shore	"Vetera	ns'					
altimore,	교 문문을 .	-	4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Service Licens			emete		ross of Facility	7/14/99	Beulah	, Mary	land		
n	Depa Impo any I		2 Chall	Phan		Mo	ore Fund	eral Ho	me, P.A.					
	-	-	23a. Pert1. Eller the disease, or comp	lications that caused	the death				Street, Do			d 21629		
)	Physician /Medical		shock, or heart failure. List only c	ne cause on each lin	10.		CULAR DIS				Int	terval Between nset and Death		
	Examiner		disease or condition resulting in death)	a		s e conseq	1275	LNJL			1			
-	D ==	ner												
o,	be executed sician and buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or a	is a conseq	uence of):							
68/60,	tificete be ng physici es the bu	으	Cause (Disease or Injury that initiated events resulting In death) Last	c	Due to (or a	s a conseq	uence of):							
ROX	endir r use	Physician/Med		d							1			
-	he att	8	Part II. Other significant conditions co	ntributing to death bu	t not result	ing in the u	nderlying cause g	iven in Part I.	23b. Did	tobacco una co	ntribute 10 th	e cause of death?		
s, P.O.	# 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	۾							_ 10	Yes 2X No	3 Probeb	oly 4 Unknown		
Hecords	as been s	Completed							24a. We	s an autopsy ormed?	availa	autopsy findings able prior to eletion of cause ath?		
	The la	ĕ							18	Yas 2□ No	1,084	res 2□ No		
VITA	ysicien: The law is certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?						Death (Check only	one)				
5	> 00	0	1 X Yes 2 No	Hospital: 1 Inpatie	nt 2 E	R/Outpatien	I SU DOV		ing Home 5 Res	idence 6 DOtt	ner (Specify)			
5	Attending Ph ir death. sctor: After thi by the funeral	ation:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injur (Month, Day	Year) 2	8b. Time of Injury	W	uryat ork? ⊒Yes 2⊡No		how injury occur	red			
DIVISION	al or Attend is efter death at Director: / ed in by the i	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	iry - At hom (Specify)	ie, farm, str	eet, factory, office		28f. Location City or To	(Street and Numbown, Stete)	ber or Rural R	loute Number,		
ě	Hospi 24 hou Funer tely fil	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of iner: On the basis of and manner sta	examinatio	edge, death n and/or im	occurred at the restigation, in my	time, date and p opinion, death	place, and due to the occurred at the time	, date end place,	and due to th	e cause(s)		
	within 2 to the comple	Σ	29b. Signeture end title of certifier		1	4	29c. Licer	nse number		29d. Date signe		y, Year)		
	N	1	30. Name and address of person who c	A VI	ath (Item 2	17/1	np	.M.E		JULY 12	, 1999			
	7		Stephen S.	Rade				nn Stre	et, Balti	more, Ma	ryland	21201		
			24 Date Blad Whath Day Verst	20 0	de Ciana	***								

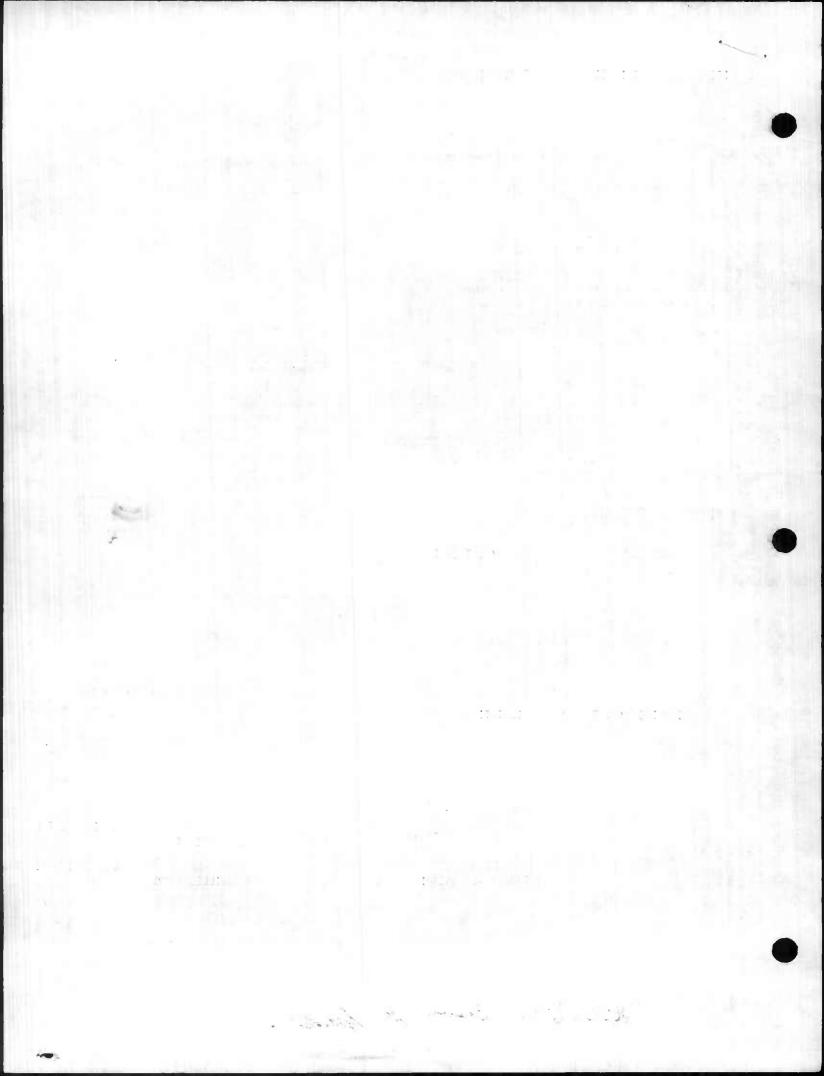
DHMH 16 Rev 6/95

Registrar

JUL 1 3 1999



DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1		Decedent's Neme (First, Middle, Let			rtificate of			Reg. No.	3. Time of Deeth
	Physic /Medi	cal		roy Dodson, Sr.			4b. City, Town, or Loca	Month July	Dey (19990550
	Exami	ner	Deaton Specialty Ho				Baltimore		4c. County	or Dealit
	Funeral Director		0/3 00 00 12	ax 7. Age (In . CX, M 2□ F	yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Dete of Bird (Month, Da June 16,	² . 1945	9. Birthpiece (State or Foraig Washington, D.C.
	fand		Usuel Residence of Decedent 10e. Stata 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limit
	a-f sh	ctor	Maryland Prince Geo	orge's		L	andover			1 ☐ Yas 2 □ N
	23a or 28	Funeral Director	10e. Street and Number 8002 Ray Leonard Co	ourt		10f. Zip Code	20785		10g. Cülzen of V	/het Country?
21215-0020	1 and 2 should be filled within 72 hours after death with the Maryland Health and Mental Hyglene. The strained other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examinet must be notified at	by	11. Maritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedant Ever in Armed Forces? 1 ☐ Yes 2 ☐ No lt Yes, Give Year or Detes:		Wes Decedant of It If Yes, specify Cub	tispenic Origin? (Speci an, Mexican, Puarto Ri Specify:	ify Yes or No can, atc.)	14. Race Blac Specify	- Amarican Indian, k, Whita, etc. Black
15-0	within 72 ho	ietec	15. Dacedent's Ed (Specify only highast gra	ucation da completed)	/Chia	dent's Usuei Occup	descine most of works of		16b. Kind of Bu	
212	d within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Far	ni ly Care P	arent		Helping C	hildren Grow, Inc
Maryland	d 2 should be filed that the and Mental Hyg 7 Is marked othe traumatic event,	To Be C	17. Father's Nama (First, Middla, Last) Howard Dod	a)						
	alth and N 27 Is mail or traumai		19e. informent's Neme/Reletionship A	(ppe Print) fe)	18602***	Ray Leonard	and Number of Bural	BOUER Number	ir Gibaridowi2	978 Sip Coda)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If frem 27 is any Injury or other tra-		20e. Method of Disposition 1 ☑ Suriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removel from Stete	b. Place of Dispo cemetary, cra INCO IN ME	osition (Nama of matory of other pla MOMI all CEME	Stery 7/1	Date 12/99	Suitland,	city or Town, State Mary land
	permit. Departn Importa any inju		21. Signeture of Funeral Service Licen.	broker	22		ess of Facility ome, I Place, N.E.		aton. D.C.	20019
	Physician		23e. Prit. Enter the disaase, or comp hisk, or heert teilure. List only o	olicetions that caused the cone cause on each line.	leeth. Do not en					Approximate interval Between Onset end Death
	/Medicai Examiner		Immediate Ceuse (Fine) disaese or condition resulting in deeth)	501	elec					10 day 8
j.		Je L	roosing in assiny	(1						
E	nd ransit	Examiner	Sequentially list conditions,	6 mfhs						
68760,	be axe ician a burial-	ai Ex	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	1.5						
	certificata be axecuted iding physician and isa as the burial-transit	//Medical	resulting in deeth) Last	d. Hepan	o (or as a consec	wence of):	77			5413
. Box	death a atten of for u	Physiclan/M	Pert II. Other eignificant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	ven in Pert i	23h Did i	obacco usa cor	tribute to the cause of death
P.O.	at tha d by th atache	Phys					acity		Y•• 2 No	3 Probably 4 Unknow
Vital Records,	The law requires that the death cert ate has been signed by the attendin- page 2 should be deteched for use	Completed by	8 contractures.	Chromic aina	11-01		V	24e. Wes perfo	en eutopsy rmed?	24b. Were autopsy findings aveilable prior to completion of causa
Re	i cian: Tha lav certificata has rector, paga 2	omp						101	′es z∰No	of death?
Ta I	ilan: J	Bec	25. Was case referred to medical examiner?				26. Place of Death (
	Physician: r this certificantal director,	2	1 ☐ Yes 2 ÎP No		2 ER/Outpatier		4 LI NUISING HOME			
Division of	To the Hospital or Attending Physician: Tha lav Within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	Certification:	27. Menner of Deeth 1 DNeturel 5 Pending 2 Accident invastigation 3 Suicida 6 Could not be	28e. Dete of fnjury (Month, Day Yea		M 1 🗆	Yes 2□No		ow injury occurr	No.
Divi	ital or Aturs after of rai Direct	Certifi	4 Homicide determined 256. Place of injury - At nome, farm, street, factory, onice building, etc. (Specify)							
	To the Hospital of within 24 hours a To the Funeral Completely filled in	edical	29e. Certifier (Check only one) 1 Certifying Phy	efcian: To the best of my iner: On the basis of examend menner steted.	knowledge, deeth ninetion end/or in	n occurred et the tir vestigetion, in my o	ne, dete and piece, end pinion, deeth occurred	d due to the d et the time,	ceuse(s) end me dete end plece, e	nner es stated. nd due to the cause(s)
	To the Within To the comple	Me								(Month, Day, Year)
	7						D36494		7/010	19
	(10)		30. Name and address of person who c	ompleted cause of deeth (Item 23a) (Type,	Print) Sam ch	nles st B	alhmac	m) 21	೮ 0
	Sta Registr	- 1	31. Date filed (Month, Day, Year) 13 1399	32. Registrer's Si		low	11			

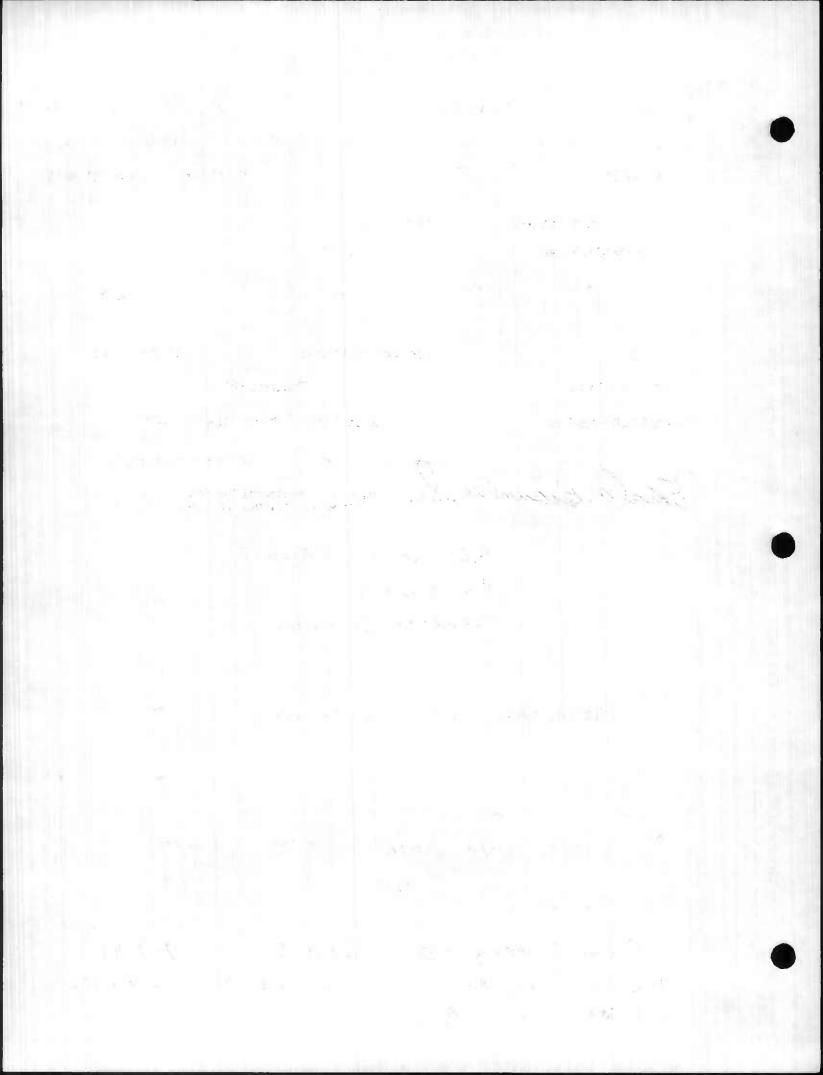
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		1 Decedent's Na	me (First, Middle, L	ectl		Cer	tificate o	r Death	2. Date of D	Reg. No.	3 3	ime of Death		
Physicia	an	_			1 = 4				Month	Day	Year	: 46 A.M		
/Medic				ve street and number				4h City Town	or Location of Dea			.467111		
Examin	er							CLINTO		′		4		
	•	5. Social Security		Sex 7.A	ne (In vrs.	last birthday)	If Under 1 Ye	ar If Under 24 H			9 Birtholaca			
Funeral Director		577 <u>44</u> 79 Usual Residence	38	1□M 2)(0F	59	Yrs.	Months Day	s Hours M	8. Date of Bi (Month, D 04/22/1	ay, Year) 940	Country) Washingto	Stete or Foreign		
the Maryland 28e-f show	'n	10a. State	10b. County			y, Town or Lo						side City Limits ☐ Yes 2 ☐ No		
Ne M	ecto	MD	Prince G	xorge's	Fo	prestvil	1			40 OW 41				
23a or 2	Funeral Director	10e. Street and N 2621 Pt	nelphs Aveni	ne e			10f. Zip Code 2074			10g. Citizen of t	what Country?			
Maryland 21215-0020 2 should be filed within 72 hours efter deeth with the Maryland and Merial Hygiene. Is marked other than "natural", or itema 23a or 28a-f show raumatic avent, the Medical Examinar must be notified at	Completed by Fune		rried 2 <mark>1</mark> X Married 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	? INo	i	Vas Decedent of Yes, specify C □ Yes 2170 N	of Hispanic Origin? uban, Mexican, Pu lo Specify:	(Specify Yes or N erto Rican, etc.)	Bla	ce - American Indick, White, etc.	dian,		
5-0	etec	(Spe	15. Decedent's E ecify only highest gi	ducation rade completed)		(Give	ent's Usuai Occ	ne during most of v	vorking	16b. Kind of B	usiness/Industry			
rithin Paris	mpl	Elementery/Sec	T	College (1-4or	5+)	life. L	OO NOT use ret	ired)			emment			
Series 4		12	APPLICATION AND ADDRESS OF THE PARTY OF THE	**		Correct	cional Of		in a definal salabili					
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aryla should I and Meni marked	2	Herbert				T			te Colbert					
Mai 12 st 12 st 1 st 1 st			Name/Relationship				helphs A			al Route Number, City or Town, State, Zip Code)				
or Heelth			iley/husban	a	venue ror	Date Date		- City or Town, S	tota					
Baltimore, semit. Peges 1 er separtment of Hee mportant: If item: iny injury or othe			Cremation 3	Removal from State	olece)				lata					
ting trant:			5 Other (Spec		Han	1 1	norial Pa		7/12/1999	Landove	r, MD			
Baltimore, Maryland 21215-0 permit. Peges 1 and 2 should be filed within 72 hr Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic avent, the Medical page.	-	611	er Service Une	1/0	ey.		Name and Add	Verse Das	eral Service	es m	20011			
-		23a. Part1. Enter	the disease, or cor	nplications that cause y one cause on each	ed the death	h. Do not ente	er the mode of o	lying, such as card	iac or respiretory	arrest,	Appr	oximate val Between		
	Medical Examiner	Immediate Cause disease or condit resulting in death Sequentially list of if any, leading to cause. Enter Uncause (Disease of that Initiated even resulting in death)	conditions, immediate forlying or injury	b. 7,	Due to (o	or as a conseq or as a conseq	uence of): L A uence of): EFF	FAILU	RĒ					
Box 6 Bath certifi ettending for use as	lan			u							i			
h.O. BOX that the death cer ed by the ettendin detached for use	by Physician/M	Part II. Other eign	ificant conditions	contributing to death	but not resu	uiting in the ur	nderlying cause	given In Part I.	23b. Dtd	l tobacco uee co	entribute to the	auee of death?		
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Division of Vital Records, P.O. Box or Attanding Physician: The lew requires that the death cert after death. Director: After this certificate has been signed by the ettending in by the funeral director, page 2 should be detached for use.	Completed by				-				24a, Wa	s en eutopsy ormed?	available	topsy findings prior to on of cause		
Rec	du								-		of death	_		
Vital Re									7 10	Yas Zhano	1 Yes	2X No		
of Vita Physician: this certific	Be	25. Was case refe examiner?		Hospital:				Other:	Death (Check only					
Physical directions of the second of the sec	ို	1 Yes 2		1 Sunpat		ER/Outpatien	T SLI DOA	4 LI Nursing	Home 5 Res					
Ing Fing F	Certification:	27. Manner of Dea	5 Pending	28a. Date of In (Month, D	ay Year)	28b. Time of Injury	V	Vork? ☐ Yes 25€No	200. Describe	how injury occur	160			
SiC tend the the	cat	2 Accident 3 Suicide	Investigation 6 Could not	na -	A	MIA			20f Location	(Street and Numi	har or Burai Bou	to Number		
or Al	ŧ	4 Homicide	determine	building, e	ntc. (Specif)	y)	eet, factory, office	20	City or To	wn, State)	oor or rigitar riou	to riambor,		
Division of Vital Re To the Hospital or Attanding Physician: The Pwihin 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical Ce	29a. Certifier (Check only	1∰ Certifying P 2 Medical Exa	hysician: To the best miner: On the basis	t of my kno- of examinat	wledge, death tion and/or inv	occurred at the	time, date and pla y opinion, death of	ice, and due to the	Cause(s) and m date and place,	anner as stated. and due to the c	ause(s)		
hin 2	Med	one)	d title of andiffer	and manner s	tated.		20a 1 in	ense number		29d Date elene	d (Month, Day,	Year)		
P P P S		29b. Signature an		. James	м.	9				251		r ear /		
		30. Name and add	PISC AT	completed cause of AWAY & A 32. Regis	death (Item	23a) (Type,	Print)			•		9		
Stat	e	31. Date filed (Mo	nth, Day, Year)	32. Regis	trar's Signa	iture		7 2 4/04	100000					
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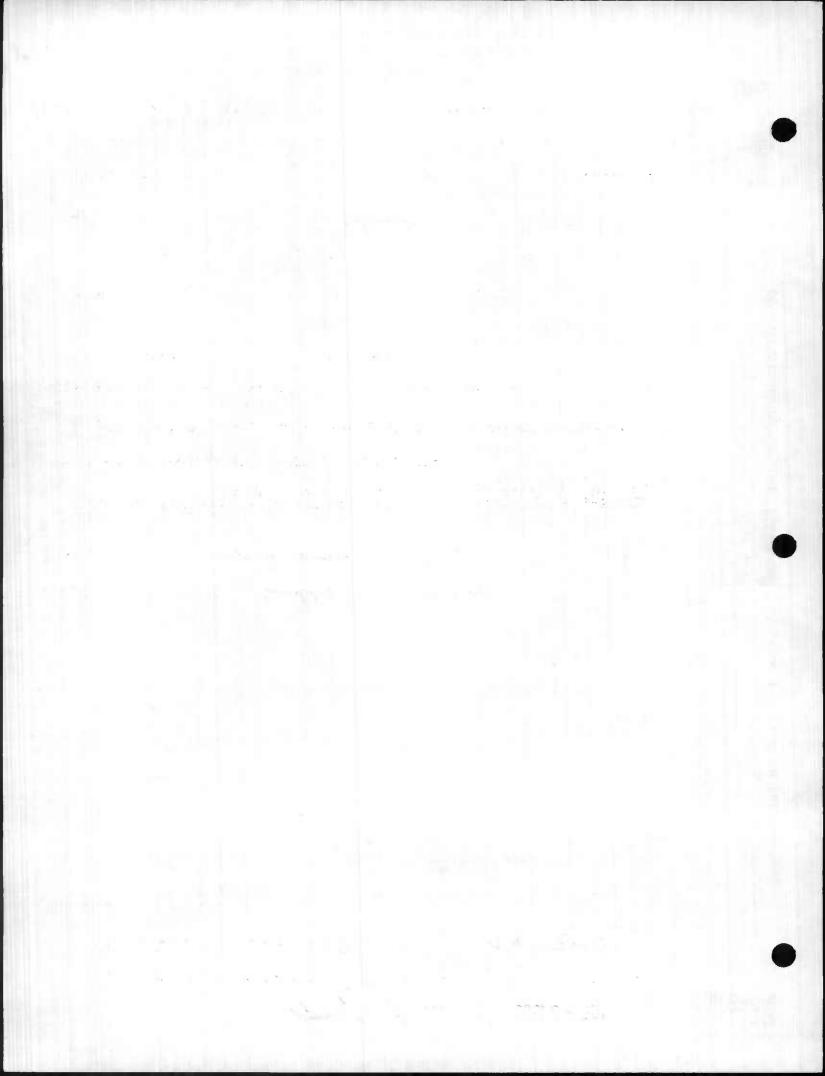


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				State of Marylar		ificate of			giene 🗸 🗸 Reg. No.	1.0100		
	Physic /Medi		1. Decedent's Nama (First, Middle, Last) MAMIE 01)	ON				2. Deta of De Month JULY	Dey	3. Time of Death		
	Examil Funeral Director		4e. Facility Neme (If not institution, give s BRAOFORD OOKS V 5. Social Sacurity Number 6. Sax 214-32-2455	156. 4 REHA	lest birthday)		4b. City, Town, or CLINTON If Undar 24 Hrs Hours Min	MO.	pRinct th y, Year)	of Death ### GFORGE'S CO. 9. Birthplaca (Stata or Fore) Country) Easton, MD		
	land		Usual Residence of Decedent 10a. Sfefe 10b. County	10c. Cit	y, Town or Loce	ntion				10d, Inside City Limit	its	
	a-f sho	ctor	MD Prince (George's	Oxon H	/i11				1 Yas 2 N		
	with the	Funeral Director	10e. Street and Number			10f. Zip Code	_		10g. Citizen of W	haf Country?		
	ms 23	Jerai	1181 Marcy Avenue	2. Wes Decedant Evar in U	,S. 13. W	2074 as Decedent of F	5 lispanic Origin? (S an, Maxican, Puar	Specify Yes or No	USA - 14. Race	- American Indien,		
020	should be filed within 72 hours efter death with the Maryland nd Mental Hygiene, marked other than "natural", or items 23a or 28a-f show urnatic event, the Medical Exertine must be notified at	þ	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yeer or Detes:	1	Yas, specify Cubi	an, Maxican, Puar Specify:	to Rica <i>n</i> , atc.)	Specify:	k, Whita, etc. Black		
21215-0020	"natural", or	Be Completed	15. Decedent's Educ (Specify only highest grede	ation completed)	(Giva ki	nt's Usuel Occup nd of work done	during most of wo	orking	16b. Kind of Bu			
212	jene.	ошо	Elementary/Secondery (0-12)	College (1-4or 5+)	III. DC	NOT use retired Homema		Domestic				
pur	be filed d other event,		17. Father's Neme (First, Middla, Last)		,		18. Mother's Ne	's Neme (First, Middle, Meiden Sumama) Fannie Blackwell				
Maryland	should of Men marks metic	2	Jacob Smith 19e. Informant's Neme/Reletionship (Typ.	ne. Print)				State Zin Code)				
, Ma	and 2 setth ar 27 is or treu		Rosetta Hawkins-	a Number, City or Town, State, Zip Code) Hill, Maryland 20745								
altimore,	permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other treumatic event, the Mades.		20e, Method of Disposition 1 ☐(Burial 2 ☐ Cremetion 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	City or Town, State Maryland								
Balti	Departm Departm Importa any Inju		21. Signeture of Funeral Sarvice Licansa	FUNERAL HI Sh, DC 2002	om							
			23a. Part1. Enter the disease, or complice ehock, of heert fellure. List only one	ations thet caused the deet						Approximate Interval Between		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a.	FUPX	eTM!	H O	nyhon			Onsef and Death		
	uted Insit	Examiner	. b.			1 0						
68760,	ficata be executed physician and is the burial-transit	dical Exa	Sequentially ilst conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	,	r as a conseque							
Box 68	auth certificat attending phy for use as th	w	resulting In death) Lest		1 83 8 001136q06							
	the atte	Physician/M	Part II. Other significant conditions cont	ributing to death buf not res	ulting in the und	erlying cause giv	ren in Pert I.	23b. Did	tobacco use con	tribute to the cause of deat	th?	
s, P.O	es that tha da igned by the be detached	by Phy	(ATON)					10	Y88 2000	3 □ Probably 4 □ Unkno	nwc	
Records,	been s	Completed							en autopsy rmed?	24b. Were autopsy findings available prior fo completion of cause of death?	6	
al R	The ata h							10	Yas 25 No	1 ☐ Yes 2 € No	**	
of Vital	Physician: The this cartificata ral director, pag	o Be	25. Wes case referred to medical examiner?	ospitei:	ER/Outpatlent	3□ DOA Oth	or: d	ath (Check only	on <i>e)</i> denca 6 □Othe	or (Specify)	-	
ion of	ding th. Aftar	ation: T	27. Menner of Deeth 15. Netural 5 Pending 2 Accident Investigation	28a. Dete of injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		1	how injury occurr			
Division	* 5 E C	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, ferm, stree	t, fectory, office		28f. Location (City or To	Street end Numbe wn, Stete)	er or Rural Routa Number,		
	To the Hospital of within 24 hours at To the Funeral Decompletely filled in	Medicai (29e. Certifler (Check only one) Certifying Physical Examination (Check only one)	clan: To the best of my kno er: On the basis of examina and manner stated.	wledge, deeth o tion and/or inve	occurred at the tir stigation, in my o	ne, date and piece pinion, daeth occ	e, and due to tha urred at the time,	cause(s) end me date and plece, s	nnar es steted. and due to the cause(s)		
	omp omp	M	29b. Signeture and title of certifler			29c. Licens	e number		29d. Data signed	(Month, Day, Year)		
	(2)		30. Name and address of person who con	npleted cause of deeth (Iten	23a) (Type, Pr	int) 1#:	114	- 10/0-1	1/14	20111		
	Sta	te	31. Dete filed (Month, Day, Year)	↑)	iture .	MH. C	7 //	. magn	(IVI)	0179		
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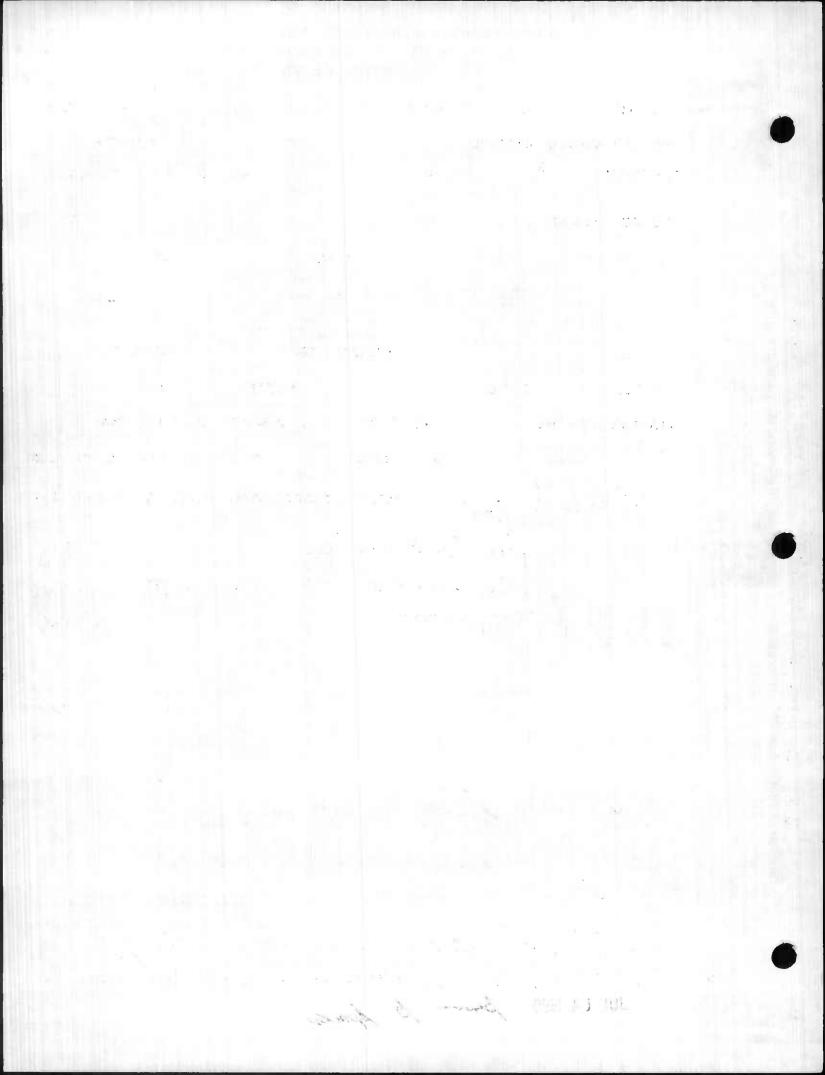
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			1. Decedent's Name	(First, Middle, La	st)						2. Data of De	eath		3. Tima of Death	
	Physicia		Mari	a Joseph	nine DiSim	one					Month July	7, 1999	Yaar	7:10 PM	
	/Medica Examine			-	a street and number)	OHC				4b. City, Town, or I	1		of Deeth	7.10 111	
	LAdinine	1	Devlin Ma	nor Nurs	ing Home					Cumberla	nd	Δ11	egany	17	
-	Company		5. Social Security Nu			a (In yrs.	last birthde		ar 1 Yaar	If Under 24 Hrs.	8. Date of Bi			lace (Stata or Foreign	
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	ahow		10a. State	10b. County		10c. Cit	y, Town or						1	0d. Inside City Limits 1 ☑ Yas 2 ☐ No	
	Ne M	20	MD	Alleg	gany		Cum	berlar	-			40- 011			
	ath with the Marylan 23a or 28a-f ahow	al Director	701 Fur	nace Sti	reet			101. 2	ip Code 2]	1502		10g. Citizen of V USA	vnat Cour	ntry ?	
020	urs efter de	by Funeral	11. Marital Status 1 □ Never Marrie 3 ☑ Widowed 4		12. Was Decedent Armed Forces? 1 Yes 2 14 Yes, Give Year or Dates:		,S. 1			Hispanic Origin? (Sean, Mexican, Puart Specify:	pecify Yas or No o Rican, atc.)	o- 14. Race Blace Specify	k, White,	an Indian, atc. nite	
21215-0020	n 72 ho	leted	(Specil	15. Decedent's Ed y only highest gra	ducation ade com <i>pleted)</i>		16a. De	cedent's Us	ual Occu rork done	pation during most of wor	rking	16b. Kind of Bu	isiness/Inc	dustry	
212	d withly diene.	E O	Elementery/Secon 6th	dary (0-12)	College (1-4or 5	5+)	, m					Home			
Pu	d othe		17. Fathar's Name (F	First, Middla, Last,)					18. Mother's Nan	ne (First, Middle	, Malden Sumam	a)		
<u>la</u>			John	-	C	apor	uscio			Concet	ta		Di	Traglia	
Maryland	12 should be in and Mental I is marked or traumatic eve		19a. Informant's Nar	me/Relationship (Type, Print)		19b. Ma	ailing Addre	ss (Stree	t and Number or Ru	rel Route Numb	oer, City or Town,	Stata, Zip	Code)	
	and 2 ealth a n 27 l		Mary Jane	Eshlema	n/Daughte										
re			20e. Method of Dispo		Cumberland, Md. 21502 Date 20c. Location - City or Town, Stata										
E	Page ent o nt: If									1	/10/99	Oakland.	Mar	vland	
Baltimore,	pemit. Pages 1 Department of H Important: If the any Injury or of phos.	17. Fathar's Name (First, Middla, Last) John ————————————————————————————————————									120100	ountium,	11012	y zana	
ä	Ped de la company de la compan	-	DQ.	MA. A-	ome										
	10000	+	23a, Part 1, Enter the	e disease or com	plications that caused	the deat	h. Do not	32 S	Sec	cond Stre	et, Oak	land, Md	21	550 Approximate	
	Dhusisian		Stewart Funeral Home 32 S. Second Street, Oakland, Md. 21550 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bronset and Conset												
	Physician / /Medical		Immediata Cause (F	inal		Œ			1.					2	
	Examiner		mmediate Cause (Final disease or condition resulting In death) e. Congressive Heart Factor 7 growth of the consequence of the												
		-			0								i		
	nsit	Examiner	Sequentially list conditions. Due to (or as a consequence of):										i	year	
	ificate be executed g physician and es the buriel-transit	X	Sequentially list con- if any, leading to immoduse. Enter Under Cause (Disease or In	ditions, nediate		Due to (d	ras a con:	sequence of):				1		
68760,	be	8	Cause (Disease or Inthat Initiated events	njury	c										
387	physes the	edical	rasulting in death) Li	ast		Due to (o	r as a cons	sequence of):				1		
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Box	attending for use	Physician/M													
o'	by the	78	Part II. Other signific	ant conditions c	ontributing to death b	ut not res	ulting in the	e underlying	cause g	van in Part I.				o the causs of death?	
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of Vital Records,	sign d be	à									040 1110		24b W	ere autopsy findings	
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ec	has b	0												death?	
H		3									1 🗆	Yas 2210	1[☐ Yes 2☐ No	
/ita	Physician: 1 this certifical	9	25. Was casa refarre examiner?	ed to medical						26. Place of Dea	ath (Check only	one)			
1	hysic this co	2	1 ☐ Yes 2 ☐ ♣	ło	Hospital:	ent 2	ER/Outpat	tient 3 🗆 🛭	OA O	her: 4 Norsing I	lome 5 Res	idence 6 DOth	er (Specil	<i>y</i>)	
	ding Ph th. After th funeral	Ë	27. Mannar of Death	5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time Injur		28c. Inju	iry at ork?	28d. Describe	how injury occur	red		
000	Attending in death.	ER	2 Accident	Investigation				М	1	Yes 2 No					
Division	rs efter death. al Director: After ted in by the funera		3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		ury - At h c. <i>(Specit</i>	ome, farm,	street, facto	ory, office			(Streat end Numb wn, Stata)	er or Rure	el Route Number,	
	Hospi 24 hou Funer itely fill	edical			nysician: To the best niner: On the basis of and manner str	examina									
	within To the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 431. Date filed (Month, Dey, Year) 32. Registrar's Signature 34. Aparth 35. Aparth 36. Aparth 37. Date filed (Month, Dey, Year)										Day, Year)			
	F S F O			mel.	いなん				Do	01756	5	July 8.	192	9	
	16.	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ATBolline ITD 922 N2T1 Hay L2V2							1 - 1 -	(4 17	2 2 10	-01			
	State		31. Date filed (Month	n, Dey, Year)	32. Registr		ture	1	7	L201	- 11	13			
	Registra	•		JUL - 9		Special Property of the Parks	~ /	0.	doa	do					



State of Maryland / Department of Health and Ment	al Hygiene

iniam	1. Decedant's Nama (First, Middla,	Last)		Certifica			2. Data of Deet		Vana	3. Time of Death		
ician	GEORGE	В.	DAVI	S			Month JULY	Day 12	Yaar 1999	2215		
dical niner	4a Facility Nama (If not institution,				4t	o. City, Town, or L		4c. County	-			
III ICI	ATLANTIC GENERA	AT HOCDITA	T			BERLIN		MORO	CESTE	D		
			Aga (In yrs. last i		dar 1 Yaar	If Undar 24 Hrs.	8. Data of Birth	177.		aca (Stata or Foraigny)		
	226-36-5328 Usual Rasidance of Decedant	1⊠M 2□F	70	Yrs. Month	ns Days	Hours Min.	JULY 3,	1929	VIR	GINIA_		
	10a. Stata 10b. County		10c. City, To	wn or Location					10	d. Inside City Limit		
ō	DELAWARE SUSSE	X	SEL	BYVILLE						1 Nas 2□N		
runeral Director	10e. Street and Number		02.2		Zip Code		1	0g. Citizen of W	hat Count	ry?		
	P.O. BOX 865				19975	5		USA				
	11. Marital Status	12. Was Decede	ant Evar in U,S.	13. Was De		spanic Origin? (Sp n, Maxican, Puarto	ecify Yas or No-	14. Race	- Amarica			
	1 X Navar Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	armed Force od 1 X Yas 2 If Yas, Giva Yaar or Date	□ No		2 X No		Hican, atc.)	Specify:	k, Whita, a			
	15. Decedant's			sa. Decedant's U	sual Occupat	tion		18b. Kind of Bu	sinass/Indi	ustry		
	(Specify only highast	grada completed)		(Giva kind of life. DO NOT	work dona di usa ratired)	uring most of work	ing					
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Daniel Daniel	17. Fathar's Nama (First, Middla, L.	ast)				18. Mothar's Nam	a (First, Middla, I	Maidan Sumam	a)			
0	GEORGE	DAVIS				MARGIE						
	19a. informant's Name/Ralationshi	ip (Type, Print)	11	9b. Mailing Addr	ass (Street a	nd Number or Rui	ral Routa Number	City or Town,	Stata, Zip	Coda)		
}	CLARENCE DRUMM	OND	R'	т. 3 вох	169-	N, FRANK	FORD. DE	LAWARE	19945	5		
-	20a. Mathod of Disposition		20b. Place	of Disposition (f	Vama of	1		20c. Location -				
J	1 A Burlal 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe		ata	TIS CEME			/19/99 R	TOHOPVI	LLE	MARYLAND		
Important: If item 27 is marked other than any injury or other fraumatic event, the Maones. To Be Compi	21. Signatur vol Funarai Sarvice Li		COR		and Addrass		117/77	JUNE VI		IMIKIDIMID		
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	resulting in deeth)	a	Due to (or es	e consequenca o	of):			Λ		03		
edical Examiner		Ce	relow	MASC	ULA	r A	coid.	ent		1 SAME		
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ŭ	Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disease or Injury that initiated evants	DIA	B378	3					4	Dane		
3	that initiated evants rasuiting in daath) Last	c	Dua to (or as	a consequance of	of):							
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								es 2 No	3 Prob	. /		
2							24a. Was a	n autopsy	24b. We	re autopsy findings ilable prior to		
2							perform	med /	COR	npletion of cause		
# 5 CO							TOWN	89 2 V No		Yes 2□ No		
	Or Was some selected and and									7163 20140		
	25. Was case referred to medical examiner?	Hospital:	/		DOA Otha	ur.	th (Check only on					
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	4 ☐ Homicida datarmin	288. Placa of	f Injury - At homa, , atc. (Specify)	farm, streat, fac	tory, office		City or Town		er or nurar	Houla Number,		
								75 22				
Las		29a. Cartifier 1 Certifying Phyaician: To the best of my knowledge, death occurred at tha time, data and place, and dua to the control of the								ated. tha cause(s)		
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DHMH 16 Rav 6/95



Funeral

Director

with the Meryland

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

218-20-3870

MD.

11 Maritai Status

10e. Street and Number

10a, Stete

Director

Funeral

P

Usual Residence of Decedent

CLOSSON

4a Facility Name (If not institution, give street end number)

10b. County

216 BRANCH STREET

1 Never Married 2 Married

3 Widowed 4 Divorced

Elamantary/Secondary (0-12) 11th

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at CLOSSON DERRICKSON Completed Hygiene. Pages 1 and 2 should be filed nent of Health and Mantel Hygi-int: If item 27 is marked other 7 is marked other traumatic event, 17. Fether's Name (First, Middle, Last) Be ROBERT J. DERRICKSON 19e. Informant's Name/Relationship (Type, Print) nt of Heelth e If item 27 is or other tra 116 BRANCH STREET; BERLIN, MD. 21801 GERALD DERRICKSON/SON 20b. Place of Disposition (Name of cemetery, cramatory or other place 20a. Method of Disposition 1 Burlel 2 □ Cremetion 3 □ Removel from State Department of Important: If any Injury or once. ST. PAUL UMCH CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signeture of Funeral Service License 23e. Perit. Enter the disease, or complicet of that caused file death. Do not enter the mode of dyling, such as cardiac or respiratory arrest, shock, a heart failure. List only one curse on each line. **Physician** /Medicai Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner sicien end buriel-transit law requires that the death certificate be executed Sequentially ilst conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): physicien s the burie Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): ettending p signed by the e Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. þ Completed page 2 anemia certificate Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of After 1 Naturai 5 Pending invastigation s after death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be detarmined 28a. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 29c. License number 29b. Signeture and title of certifier 3ronder D29505 reacris ame and add ass of person who completed causa of deeth (Item 23a) (Type, Print) 4114 5302 CHINABERRY DR SALISBURY GREGORIO BELLOSO, MD 31. Dete filed (Month, Dey, Year) JUL 0 8 1999

JOHN

12. Wes Decedent Ever in U,S. Armed Forces?

Year or Dates:

College (1-4or 5+)

Yes 2 No WW11

BERLIN NURSING & REHABALITATION CENTER

1√ M 2□ F

6. Sex

WORCESTER

15. Decedent's Education (Specify only highest grade completed)

DERRICKSON

10c. City, Town or Location

BERLIN

LABORER

7. Age (In yrs. last birthdey)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death Month 1999 9:50 AM 30 JUNE 4b. City, Town, or Location of Death 4c. County of Death BERLIN WORCESTER If Under 1 Year Months Deys If Under 24 Hrs. 8. Date of Birth AUGUST 13,1926 9. Birthplece (State or Foreign Hours SALTSBURY, MD. 10d. Inside City Limits 1 Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. Specify: AFRO-AMERICAN 1□ Yes 2 No 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry POULTRY PROCESSOR 18. Mother's Name (First, Middle, Maiden Sumame) HATTIE BRITTINGHAM 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State BERLIN, MD. JOLLEY MEMORIAL CHAPEL 1213 jersey ROAD; SALISBURY, MD. 21801 Approximate Intarval Between Onset and Deeth e Cerebrovasculas Pines

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

200 No 1 Yes 2 No 17 Yes

Other: Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, Stata)

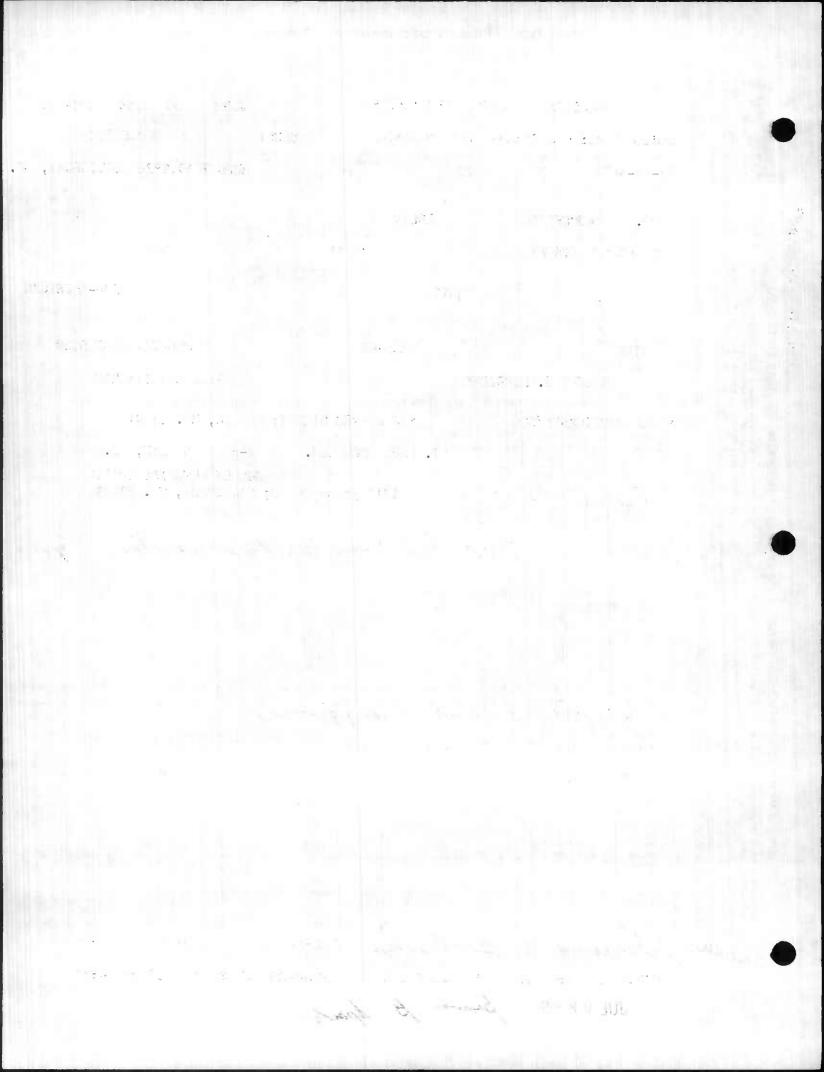
29d. Date signed (Month, Day, Year) 30 -99

MD 21801 410-341-6321

Registrar

32. Registrer's Signature

Sparks



X

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month **Physician** 10, 1999 4:55 P.M. MARY DEWEY JULY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING & REHABILITATION CENTER BERLIN WORCESTER 8. Date of Birth (Month, Day, Year) June 8, 1915 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplece (State or Foreign Country) Great Britan **Funeral** Months Days 1□ M 25 F Hours 212-26-3855 Director 84 Usual Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Tyas 2 No Director Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 6 US Rt. 50 and Rt. 113 21811 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or froms 23a any injury or other tranmatic event, the Men Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2√ No Specify: White p 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Hotel Housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) William Joseph Rogers Mary Buckley 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Patricia J. Cropper/Daughter 106 Fairfield Ct., West Chester, PA 19382 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal from Stete 7/12/99 Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory 21. Stuneture of Funeral Service Licenses 22. Name and Address of Fecility M01051 Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications het caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, Approximata Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 | Yes 2 | No 3 | Probably 4 M Unknown Odsan Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Ves 2X No 1 ☐ Yes 2 No Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 24 hours after death.

Funeral Director: After etely filled in by the funer 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated.

Discretifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated. (Check only one) To the P within 2 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number approx D02026 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 3 46 TEAL CIRCLE, BERLIN, MD. 21811 DR. FEDERICO ARTHES, M.D. Dey, Year) 32. Redistrer'a Signature State

DHMH 16 Rev 6/95

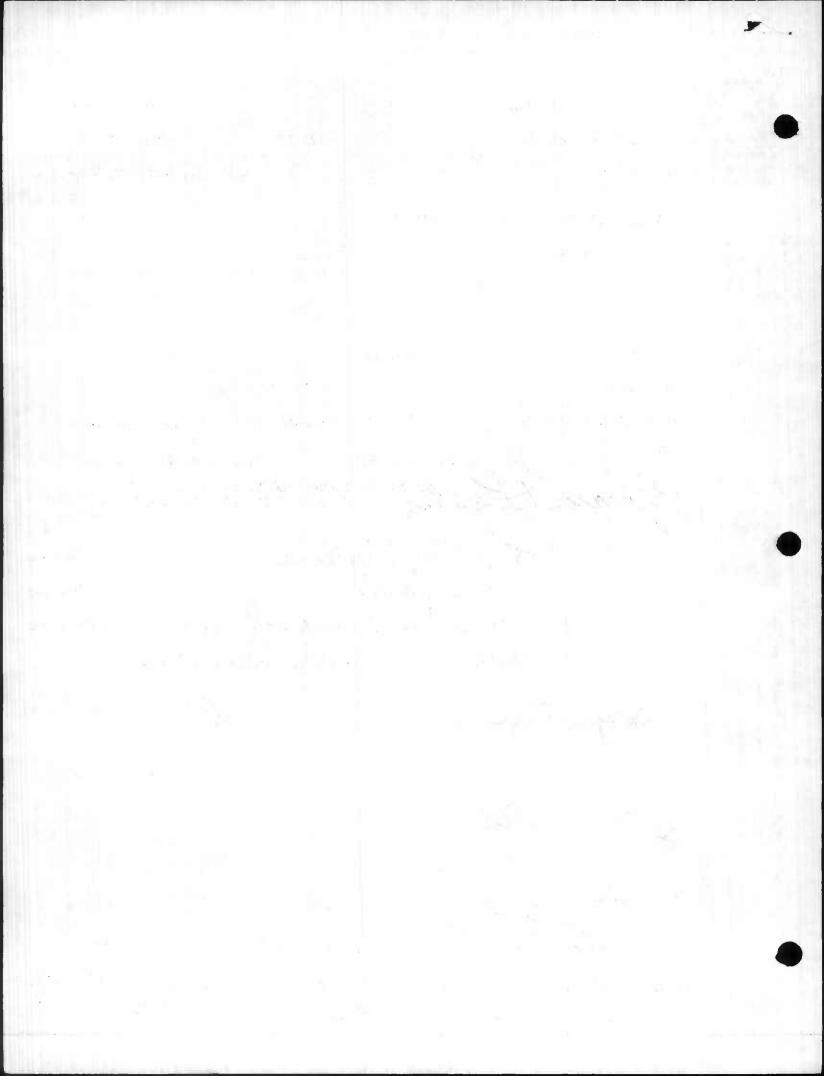
Registrar

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					State of	Marylar				Health a <i>Death</i>	nd M	lental Hy	giene Reg. No.	99	2	3/85	
	Physia	an	1. Decedent's Name	(First, Middle, La	sf)							2. Date of De Month	eth Day	/ Yes	9.5	3. Tima of Death	
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	and 2 salth ar		MARIE MASS	SEY/DAUG	HTER							DAD, WI				•	
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Ö	rs after al Dir	Cert	4 - Hollinge		Dulidin	g, etc. <i>(Specit</i>)	//					City or Tow	m, State)				
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	29b. Signature end title)/	and martin	er stated.				e number				e signed Ma			
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State of Maryland / Department of Health and Mental Hygiene 99 23786

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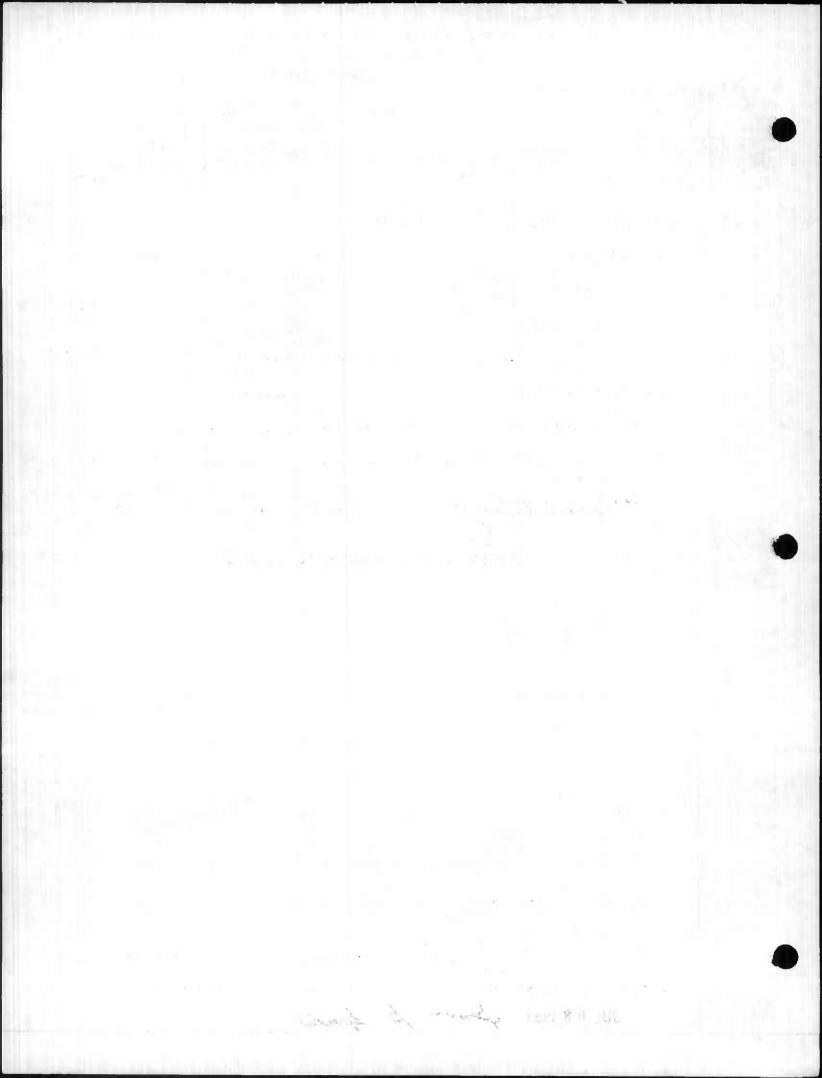
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State of Maryland / Department of Health and Mental Hygiene 9 9 2 3 7 8 7

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21215-0020 d within 72 hours after giene. ir then "netural", or hi	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or Hems 23s or 28s-f show other treumstic event, the Medical Expriner market in critical at	þ	1 ☐ Never Merried 2 🔀 Merried 3 ☐ Widowed 4 ☐ Divorced	1 XYas 2 1 If Yes, Give Yaer or Detes:	mrA ⁰ WW I	-	1 ☐ Yes 21X N		To Thousand Story	Speci		hite	9	
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To the Hospital o within 24 hours af	spita nours nerei	Medicai C	29a. Certiflet 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
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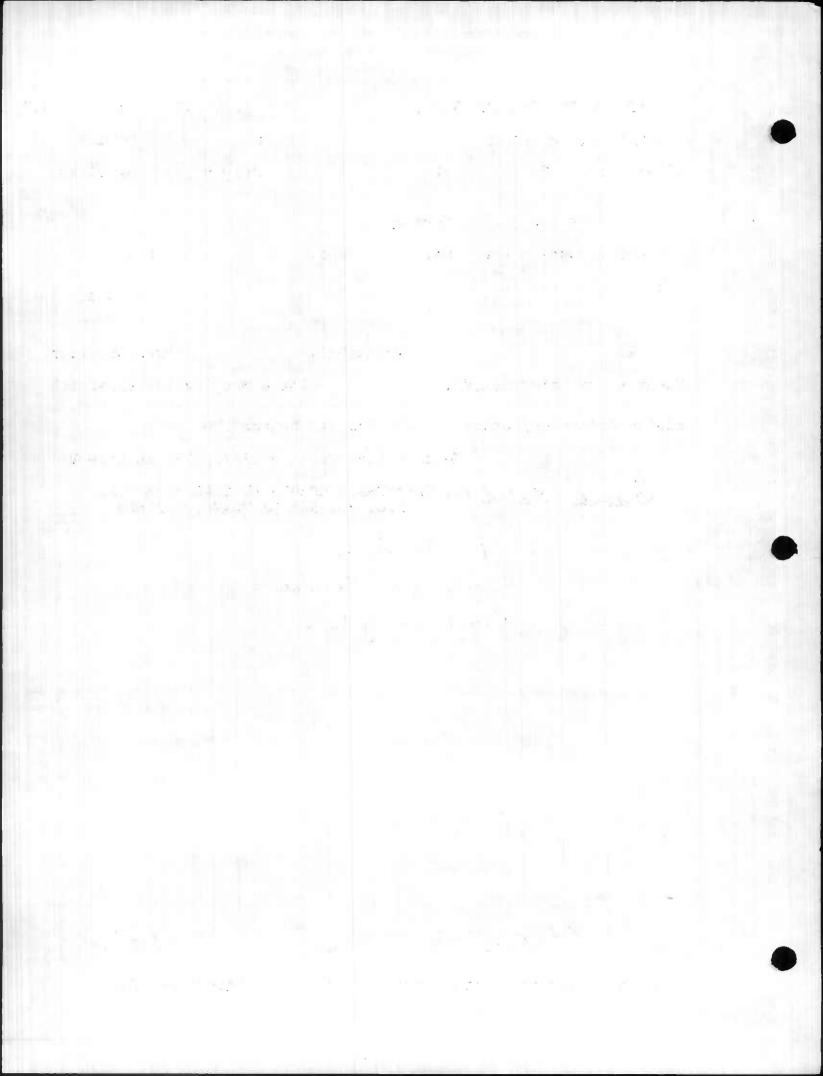


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State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** OSCAR FRANZ FRIEDRICH, JR. JULY 17 1999 1:36 A.M /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER LAPLATA CHARLES Hours Min. July 9, 1952 If Under 1 Year
Months Deys 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) July **Funeral** 217-60-5177 47 Yrs. Maryland Director Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10h County 7 is marked other than "natural", or items 23s or 28s-f shov traumatic avent, the Wodical Examinar must be notified at 1 ☐ Yes 2 No Director MD Charles Newburg 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 13665 Picowaxen Creek Rd. 20664 USA death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Wes Decedenf of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Merital Stetus permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. I mortant: If flem 27 is marked other than "netural", or flee any injury or other traumatic avent. In 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) Transportation Truck Driver 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Oscar Franz Friedrich, Sr. Eloise Mary Bailey Friedrich 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eloise Friedrich/Mother P.O. Box 313 Newburg, MD 20664 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory7/21/99Alexandria.VA 4 □ Donation 5 □ Other (Specify) 22. Name end Address of Fecility 21. Signatura of Funeral Service Licensee MOO9YSAREHART-ECHOLS FUNERAL HOME P.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory areas, 20646 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physiclan /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the buriel-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be exec Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e conseque 98 980 ō 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown signed I þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s hes certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only ona) Hospital: Panpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1) Naturai 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner placed. 29a. Certitier Medical within 24 hor To the Fune completely fi (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 29c. License number D-46979 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) COLLINS P. SEIN MD 11345 PEMBROOKE SQ. SUITE # 104 WALDORF, MD.

State Registrar 31. Date filed (Month, Day, Year)

JUL 1 9 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 12:55 PM 1999 07 02 MEHDT FARZIN /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, giva streat and number) Examiner PRINCE GEORGES PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY If Undar 1 Year | If Undar 24 Hrs. Birthplace (Steta or Foreign Country) 7. Aga (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□ F Months Deys Hours Min. Yrs. 12-18-1932 IRAN Director 218-54-6544 66 Usuel Residence of Decedent the Maryland r 28a-f show inotified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 HNo MD MONTGOMERY COUNTY POTOMAC Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours after death with I Department of Haalth and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 3 and highry or other traumetic avent, the Med of Examiner must be in page. 10600 RIVER OAKS LANE 20854 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Maritai Status Bleck, White, etc. 1 Yes 27 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Merried 1□ Yes 2☑ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) PRIVATE PRACTICE PHISICIAN 18. Mother's Neme (First, Middla, Maidan Sumema) 17. Fathar's Nama (First, Middla, Last) ASDOLLAH FARZIN SOGHRA MEHRALI 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) MARIE FARZIN - WIFE 10600 RIVER OAKS LANE, POTOMAC, MARYLAND 20854 20b. Place of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriai 2 ☐ Cremetion 3 ☐ Removel from State NATIONAL MEMORIAL PARK 4 Donation 5 ☐ Other (Specify) 7-5-99 FALLS CHURCH VIRIANIA 22. Name and Address of Facility NATIONAL FUNERAL HOME 21. Su ner Pervice Lisee 7482 LEE HIGHWAY FALLS CHURCH, VIRGINIA 22042 1 Myarlare 23a. Pert1. Entar tile distase, or emplications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or he it faithre. List only one ceusa on each line. Approximate Interval Between Onset and Death Physician hemore age Kerebral Inforcts immediete Cause (Finel diseese or condition resulting in deeth) /Medicai Examiner Due to (or as e consequenca of): Examiner Coagylopathy physician end the burial-trensit that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Overdoce Division of Vital Records, P.O. Box 68760, Physician/Medical thet initieted events resulting in deeth) Lest 80 AUVHIC replace ment use signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown artery disease p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Completed Cancer page 2 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: Othar: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of injury (Month, Dey Year) funeral 27. Manner of Death 1 Diveturel 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After 5 Pending Investigation 1 Yes 2 No deeth. 2 Accident ofter deetl Director: 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, straet, fectory, office building, etc. (Specify) à 24 hours efter Funeral Direct bletaly filled in b 4 Homicide 6 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25a Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0043662 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

WILLAM BON (E - PG HOSD/+a | 3 300/ Hosp Drive, Chevery 32. Registrar's Signeture 31. Data filed (Month, Dey, Year, 1 4 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Hygiene 99 2379(

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		shock, or heart fei	lure. List only o	ne ceuse on each	line.										Intervel Onset a	Between and Deeth
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State of Maryland / Department of Health and Mental Hygiene 99 2379

			Certificate	of Death		Reg. No.		
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Physician /Medical	John Gladstone	French			July		99	12:25pm
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	Prince George's	Hospital Cent	er	Cheve	rly	Princ	e Geo	rge's
Funeral Director	5. Social Security Number 6. 215–36–5659 Usuei Residence of Decedent	Sex 1 M 2 □ F 7. Age (In yrs. 94	last birthdey) If Under 1 Y Yrs. Months D	eys Hours Min.	(Month, De	th y, Year) 5, 1904		aca (Stete or Foreign ry) anada
Due &	10e. State 10b. County	10c. Ci	ty, Town or Location				10	d. Inside City Limits
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Page 1	1 Buriel 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spec	ify) Fo	rt Lincoln Ce	metery	07/15/99	Brentw	ood,	Maryland
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Division or To the Hospital or Attending Ph within 24 hours ether deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.						
To the To the comple			29c. Li	cense number		29d. Date signe	- /	Day, Year)
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(10)	30. Neme and eddress of person who David M. Goldman			v. #105 G	reenhelt	, MD 2	0770	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 0:05 A Lura Mae Folk 15 da /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Poath 4c. County of Death **Examiner** Goodwill Mennonite Home Grantsville Garrett If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2X F Yrs 211-38-6469 100 Director Sept 10,1898 Pennsylvania Usual Residence of Decedent with the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 891 Dorsey Hotel Road 21536 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Biack, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or thei any injury or other traumatic event, the Medical Examina-1 ☐ Yes 2 🕱 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specity 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Jonas Ash Alice Yoder 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mark J. Folk/son PO Box 195, Springs, PA 15562 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 Mg Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springs Cemetery, July 17, 1999 Springs, PA 21. Signature of Funeral Servica Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 Russay 179 Miller ST., Grantsville, MD 179 Miller ST., Grantsville sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast lura. List only one cause on each lina. Approximata Intervel Between Onset end Deeth **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ASCU burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of): attending 980 ed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. been signed by should be detac 1 | Yes 2 No 3 | Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? has 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 PNo Lo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Dascribe how Injury occurred 28b. Time of 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? Certification: 1 (PNature) 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide t 🗜 🗲 certifying Phyalcian: To the best of my knowladga, daath occurrad et tha tima, data and place, and dua to tha causa(s) and mannar as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated. 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and agdress of person who comp eted cause of death (Item 23a) (Type, Print)

State Registrar

31. Date fliad (Month, Dey, Year)

32. Registrar's Signature

DOWN & I MAN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 99 23793

14-42-2390 Residence of Decedent 10b. County	md give street and number) Memorial Ho S. Sex 1	e (In yrs. last bir 80 10c. City, Town Oa Ever in U,S. No 16a.	Months n or Location kland 10f. Zi 13. Was Dece if Yes, ape 1 Yes Decedent's Uai (Give kind of w life. DO NOT t HOL	ip Code 2155 edent of Hielerity Cubar 2 🖾 No	Oakla If Under 24 Hrs Hours Min. Oospanic Origin? (5 n, Mexican, Puer Specify: atton furing most of wo	B. Date of Birth (Month, Day) July 14 Specify Yes or Noto Rican, etc.)	Day 4, 1 4c. County Ga Vear) , 1918 Og. Citizen of W USA	Year 999 of Death rrett 9. Birthplac Country Mary 1 10d. what Country 4. American k, White, etc.	. Inside City Limits 1 □ Yes 2 ☑ No ? Indian,
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as case referred to medical					26. Place of De	ath (Check only o	ne)		
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J 100 EM 110				28c. Injury	at	28d. Describe h	ow injury occurr	red	
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend # 7.Per FH PGC 7-16-99 cr Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Deeth GREEN **Physician** Month 4:45 SANDRA JULY 10 /Medical 4a. Facility Nama (If not institution, give street end numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HEARTLAND OF HYATTS VILLE Hyattsville Prince George's If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (in yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sax Birthplace (Stata or Foraign Country) **Funeral** 577-62-0581 1 □ M 200/F Days 06-07 1945 Director Maryland Usuel Rasidanca of Decadent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic evant, the Medical Examiner must be notified at Y □ Yas 2 □ No Director Prince George's Chillum 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1821 Longfellow St. 20783 USA Funeral 12. Wes Decedant Evar In U,S. Armed Forcas? 13. Wes Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Raca - American Indien, Bleck, Whita, atc. 1 ☐ Yas 2 ☒ No If Yes, Giva Year or Datas: 1 □ Never Merried 2 □ Married 1 □ Yas 2√2 No Specify: Black þ 3 X Widowad 4 ☐ Divorcad Completed 15. Dacedent's Education (Spacify only highest grada complated) 16a. Decedant's Usuai Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If fem 27 is marked other than any Injury or other traumatic event. Elemantery/Secondery (0-12) College (1-4or 5+) Teacher School System years 17. Fethar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be William Perkins Ruth Waller 19a. Informent's Nema/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1821 Longfellow St., Chillum, Md. 20783 Karen Quander, Cousin 20b. Piace of Disposition (Nama of cematery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ↑ Burial 2 □ Cramation 3 □ Ramovai from Stata 4 □ Donation 5 □ Other (Specify) Naryland National 7-17-99 Laurel, Md. 21. Signatura of Funerel Service Licensae 22. Nama and Addrass of Facility Raiph Williams Funeral Service
517 11th St., SE., Wash., DC 20003
23a. Part1. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or raspiratory arrest,
Approximately 100 and Ralph Williams Funeral Service Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final CIARhosis disaasa or condition rasulting in death) Examiner Physician/Medical Examiner Sequantially list conditions, if eny, laading to immediata causa. Entar Underlying Cause (Disaasa or Injury Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Ular ations þ Be Completed 24b. Ware eutopsy findings svallabla prior to complation of cause of death? 24a. Was en eutopsy performed? mombosis labetes 1 Yas 200 No certificate 1 □ Yas 2 □ No 25. Was case rafarrad to medical axaminar? 26. Pieca of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 Yas 2 No this 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Describe how Injury occurred 5 Panding Invastigation 1 ☐ Yas 2 No 2 Accidant 6 Could not be 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, streat, fectory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida

Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Records, Division of Vital To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral is Medical

Baltimore, Maryland 21215-0020

29a, Cartifiar (Check only one)

tix Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated.

29b. Signatura and titla of certifie

29c. License number

29d. Deta signed (Month, Day, Year)

30. Name and address of pers

Red MYATTSVILLE MD 20181 31. Data filed (Month, Dey, Year)

JUL 1 6 1999 32. Registrer's Signature

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23795

		Certificate of Deal		Reg. No.	
Physi			2. Date of D Month		3. Time of Death
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aryla should nd Mer marke	2	Garfield Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nur	Angie G. D	-	a, Zip Code)
T d Z		Keith Gant - Son 1837 Independence	Ave., SE	Wash., DC	20003
Page nent o		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, crametory or other place) Maryland National Cem	7/15/99 etery	Laurel, Ma	
Baltimo		21. Signature of Funerel Service Licensaa 22. Nama and Addrasa of Fa Tyrone J. You 710 Young day		Services	2 20011
The taw requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disaase or injury that initiated events reaulting in death) Last Dua to (or es e consequence of):	paxly		Approximate Interval Between Onset and Death
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Division of Vital Records, F or Attending Physician: The law requires tha after death. Director: After this certificate has been aigned in by the funeral director, page 2 should be de	Completed by I	COPP, HTN, CVA, Sacral deci	24a. Wa	as an autopsy normed?	b. Were autopsy findings aveilable prior to completion of cause of death?
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f Vital ysicien: Th is certificate director, pa	o Be	Hospital: Hospital: Constinut Consti	ace of Death (Check only Nursing Homa 5 🗆 Ra	4.	inecify)
On of Ing Phys After this funeral di	on: T		28d. Dascrib	e how injury occurred	
Division of Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident invastigation May 4 1999 M 1 Yes 2 Sulcida 8 Could not be datarmined 28a. Piece of Injury - At homa, ferm, street, factory, office building, etc. (Specify)	28t. Location	(Street and Number or own, State)	
Di To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	23s. Certifier (Check cnly tops) Certifying Physician: To the best of my knowledge, deeth occurred at the time, deta construction of the basis of axamination end/or invastigation, in my opinion, cand mannar stated, and mannar stated.	and place, and dua to the death occurred at the time	a caus (a) and mannar a, data and piace, and c	as atated. Jue to the cause(s)
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To		dan Decky is OME 10004	128	Jul 15	, 1999
		30. Nama and addrass of person who completed ceusa of daath (Itam 23a) (Type, Print) 2/0/1 LA N. BRECHEL, 50 DIME 5/1/06 31. Dete filed (Month, Day, Year) 32. Registrar's Signature	redical p	Park D	02
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State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death

sician and buriel-transit Box 68760. physician the buris 680 P.O. bengia be det Records. page 2 (certificate of Vital Attending Physician: funeral director, this After Division deeth. ster deeth 3 8 filled in 24 hours

21215-0020

Maryland

Saltimore.

1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10 JULY 1999 0012 GRAY TERELL /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12205 SWEETWOOD PLACE WALDORF CHARLES If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months Days Hours Min. (Month, Day, 6. Sex 1 XM 2 F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign
Country) **Funeral** Days Year) 20 Director 212-94-4067 JULY 15,1978 LaPlata, Md Usual Residence of Decedent the Meryland 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits Yes 2 No MD Director CHARLES WALDORF notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant ben 727 BRANDON CIRCLE 20602 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 M No If Yes, Give Year or Detas: 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indian. Black, Whita, etc. filed within 72 hours after 1 Never Married 2 Married 6 1 ☐ Yes 2 No Specify: Specify: BLACK Hygiene. other than "natural", o þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th MACHINE GERATOR BERETTA U.S.A. CORP. permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe may Injury or other treumads event, page. 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) 89 ROBERT T.EO KNOTT PATRICIA PATTY GRAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20602 19a. Informant's Name/Relationship (Type, Print) PATRICIA GRAY - MOTHER 727 BRANDON CIRCLE, WALDORF, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 7. 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART CEMETERY 17-99 LaPlata, Maryland 21. Signature of Funeral Service Licenses TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one caused the death. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown ģ 24a. Wes an autopsy performed? 24b. Were autopsy tindings available prior to Completed completion of cause of death? 1 Yes 2 No 1 PYes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) To No Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury Francisco (Month, Day Feat 128b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: SUS CUL 5 Pending investigation 1 Natural Shor 7-10-99 1 Yes 2 No 00 10 2 ☐ Accident 504 37 Suicide 6 Could not be 28e. Place of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Sweetwood Place 12205 Scene 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. adicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JULY 10, 1999 O.C.M.E 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ler 111 Penn Street, Baltimore, Maryland 21201 JUNIA 2. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

from the sounds

9001 8 L- 181.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 23797

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State of Maryland / Department of Health and Mental Hygiene 99 23798

					Ce	ertificate of	Death	R	eg. No.		
			1. Decedent's Neme (First, Middle, Le	ist)				2. Data of Deat		Veen	3. Time of Death
	Physicia		MARY	ELIZABETH		GILMORE		July 5	Day 1999	Yaar	6:55 PM
	/Medic Examin		4a Facility Nama (If not Institution, give				4b. City, Town, or	Location of Death	4c. County	of Death	
	Funeral Director				Landin rs. lest birthdey Yrs.			8. Date of Birth	Year)	9. Births	olace (Steta or Foreign otry) Sylvania
	P .	-	Usuei Residenca of Decedent 10a. Stete 10b. County	100	City, Town or L	continu					Od. Inside City Limits
	e Maryla Se-f ehov	Director	Maryland Wicon		Salisb						1X Yes 2□No
	23a or 2	ai Dire	10e. Street and Number 1110 Healthway D	rive		10f. Zip Code 21	804	1	0g. Citizen of W		ntry?
020	72 hours after death with the Maryland naturel; or Heme 23a or 28e-f ehow ites Examinet must be notified at	by Funeral	11. Maritai Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Evar In Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Detes:	U,S. 13	Wes Decedent of if Yas, specify Cul	Hispanic Origin? (5 ban, Mexican, Puer Specify:	Specify Yas or No- to Rican, etc.)		k, White,	ean indien, etc. nite
5-0	"nature",	ed	15. Decedent's E (Specify only highast gr	ducation ada completed)	16a. Dec	edent's Usuel Occu	pation during most of wo	rking	16b. Kind of Bu	siness/in	dustry
21215-0020	withir then	Completed	Elementery/Secondery (0-12)	Coilege (1-4or 5+)		DO NOT use retir etician	during most of wo		Public	: Sch	ool System
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7	should Men merke	9	19e. Informent's Neme/Rejetionship		19h Mei	ling Address (Stree	et and Number or R			State 7ii	Code)
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6	the Head	-	20a. Method of Disposition		. Pieca of Disc	osition (Nema of			20c. Location -		
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68760,	ate be hysicie the bur	edical Examiner	Sequentielly list conditions, if any, iaeding to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c	(or es e conse						
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of V	5 00	0	1 Yes 200	Hospitel: 1 Inpatiant 2	☐ ER/Outpetio	ent 3 DOA	ther: 4 Nursing	Homa 5 ☐ Rasid	ence (DÉO th	er (Speci	(V) Realds
	Affing Ph After th funeral		27. Manner of Deeth 1 SNaturet 5 □ Pending	28e. Dete of tnjury (Month, Dey Year)	28b. Time injury	of 28c. inj	ury at ork?	28d. Describe h	ow Injury occurr	ed	Remade
Division	or Attendifier death	Certification:	2 Accident Invastigation 3 Suicide 6 Could not be determined	on Diego dieles A	t home, farm, s		Yes 2 No	28f. Location (S City or Town		er or Rur	al Route Number,
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	MOOL	Ž	29b. Signature and title of cadifier	edula.		29c. Licar	2826	9 2	29d. Date signed $7/8$	(Month)	Dey, Year)
	7		30. Name and address of person who	completed cause of deeth (if	tem 23e) (Type	p, Print)	OHEA	FLITHWA	Y DA	2101	201
	Stat		31. Dete filed (Month, Dey, Yeer)	32. Registrar's Sig	gnatura 4	land	I	int pu	ne o	×18	
	Registra		JUL 0 9 13:	10	~	goork	2				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician	
/Medical	
Examiner	

Funeral

Director

Director

Funeral

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Completed

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28a-f shov traumatic event, the Medical Examiner must be notified at 6 items 23a "natural", or

Department of Health and Mental Hygiana Important: If Item 27 Is marked other than any Injury or other traumatic event, the Ma once.

Baltimore, Maryland 21215-0020

Box 68760,

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Records,

Division of Vital

Physician /Medical Examiner

The law requires that the death certificate be axecuted certificate al or Attending Physicien: The street death.

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To the Foundlet

Physician/Medical

Be Completed by

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Medical Certification:

1. Decedant's Nama (First, Middla, Last) 2 Date of Death 4:05 An JOHN JULY CLARENCE HERRING 4a. Facility Nama (If not Institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) 1**X**M 2□ F Months Days Hours Min. 44 Yrs. 089-44-6627 10-14-1954 NEW YORK Usual Rasidence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits Yes 2 No MD PRINCE GEORGES LANHAM 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 9121 ALCONA STREET 20706 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedeni of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Nevar Married 2 Married 1 Yas 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) Elamentary/Secondary (0-12) 12th Collega (1-4or 5+) SELF EMPLOYED 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) **JOSEPH** CLARENCE HERRING MARY LOUISE SHERROD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Joann Stephenson - SISTER 81 UPDIKES MILL RD., BELLE MEAD, NJ 08502 20a. Malhod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Pata 1 Burial 2 Cramation 3 Ramov trom Stata 16-99 LINDEN, NEW JERSEY ROSEHILL CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatur unara con ice Licen a TUNERAL HOM TAULORIS 23a. Part1. Entar tha disaasa, or complied ons that caused the death. Do not antar the mode of dying, such as cardiac or respirately errest, shock, or heart tailure. List only one bause on each line. 1 WASHAC Approximate Intarval Batw Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) Gast 60-Inte Saquentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or Injury that initiated avants rasulting in daath) Last etaminoplen toxicity Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Wara autopsy findings available prior to completion of cause of death?

2 No 1 🗆 Yes

1 Yes X No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manper of Death

1 Natural

2 Accidant

3 Suicida

Hospital:

5 Panding invastigation

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year)

28b. Tima of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Dascribe how Injury occurred

26. Place of Death (Check only one)

6 Could not be datarmined 28a. Place of Injury - Al homa, tarm, streat, factory, office building, atc. (Specify) 4 Homicida 29a. Cartifiar

28t. Location (Street and Number or Rural Route Number, City or Town, Stata)

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. 29c. Licansa number

29b. Signatura and titla of cartitlar ym med A. mmmm m

24593

29d. Dala signed (Month, Day, Year) 7,11,99

30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Pript)

3331-TOLEDO TERRA

State Registrar

31. Data filed (Month, Day, Yaar)

JUL 1 5 1999



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) Hazel

2. Date of Death July 6, 1999 3. Tima of Death 16:10PM

10d Inside City Limits X Yes 2 No

20019

Approximete Interval Between Onset and Death

Prince George's

Funeral Director

> Director Funeral by Completed

pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturet", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at 2006.

Physician /Medicai Examiner

Examiner

The law requires that the death certificate be executed physician end the burial-transit 65 attending p the signed by the certificate has b funeral 5

Division of Vital Records, P.O. Box 68760,

or Attending Physician: after death. Director: After this certifica in 24 hours after the Funeral Dir npletely filled in To the To the comple

Be

Certification: To

Medical

Harrell 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Cheverly Prince George's Hospital Center If Under 1 Yaar | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 5. Social Security Number 8. Data of Birth (Month, Day, 1□M 2XF Months Days Hours Min Yrs. January 8, 1918 Danville, Virginia 81 577-20-3672 Usual Residence of Dacedant 10a Stata 10b. Counts 10c. City, Town or Location District of Columbia Washington 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20019 United States 4402 Quarles St., N.E. 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ Yas 2 ☒ No If Yas, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Environmental Services Government 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nathaniel Harrell Cornelia (Unknown) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 2814 Lindesfarn Terr., Ft. Wash., MD 20744 Linda Mozie - Daughter 20b. Place of Disposition (Nama of cemetary, crematory or othar place) 20c. Location - City or Town, State Data 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata 7/13/99 4 ☐ Donation 5 ☐ Othar (Specify) Glenwood Cemetery Washington, D.C. 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. · Allegar 23a. Part Enter the disease, or complications that a used the death. Do not enter the mode of dying, such es cardiec or respiretory errest, ships or heart failure. List only one cause on each line. Immediata Causa (Final diseasa or condition resulting in deeth) CAPDIOPYLMONARY ARREST RHYTHEM BISTURDANCE Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated avants Due to (or es a consequença of) Physician/Medical that initiated evants rasulting in daath) Last Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FIBRILATION ATRIAL þ 24a. Was an autopsy performed? Completed HEART FAILURE CONGESTIVE

25. Was casa rafarred to medical aminer? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA aminer? 1 x Yas 2 ☐ No

28a. Data of Injury (Month, Day Year)

24b. Were autopsy findings available prior to completion of cause of death? TI Yes 24 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 28d. Dascribe how Injury occurred 28c. Injury et Work? 1 Yas 2 No 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State)

1 Certifying Physician: To tha best of my knowledga, daeth occurred et the time, dete and placa, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, daath occurred at the tima, data and placa, end dua to tha causa(s) and manner stated. (Check only one) 29b. Signatura and titla of certifiar mn Anil- K. Mahogan

5 Panding

Investigation

6 Could not be

29c. License number D50689

29d. Date signed (Month, Day, Year) 07/06/1999.

30. Nama and addrass of person who complated gausa of death (Item 23e) (Type, Print)

ANILY MALLATER: PRINCE GEROCES HULPITAL CENTER, CHEVERLY

MARYLAND, 20785 MARYLAND, 20785 MACAHAM Y JIMA

31. Date filed (Month, Day, Yaar) .1 3 1999 State Registrar

27. Mannar of Death

2 Accidant

3 Sulcida

29a, Certifier

4 Homicida

3. Registrar's Signatura

28b. Tima of

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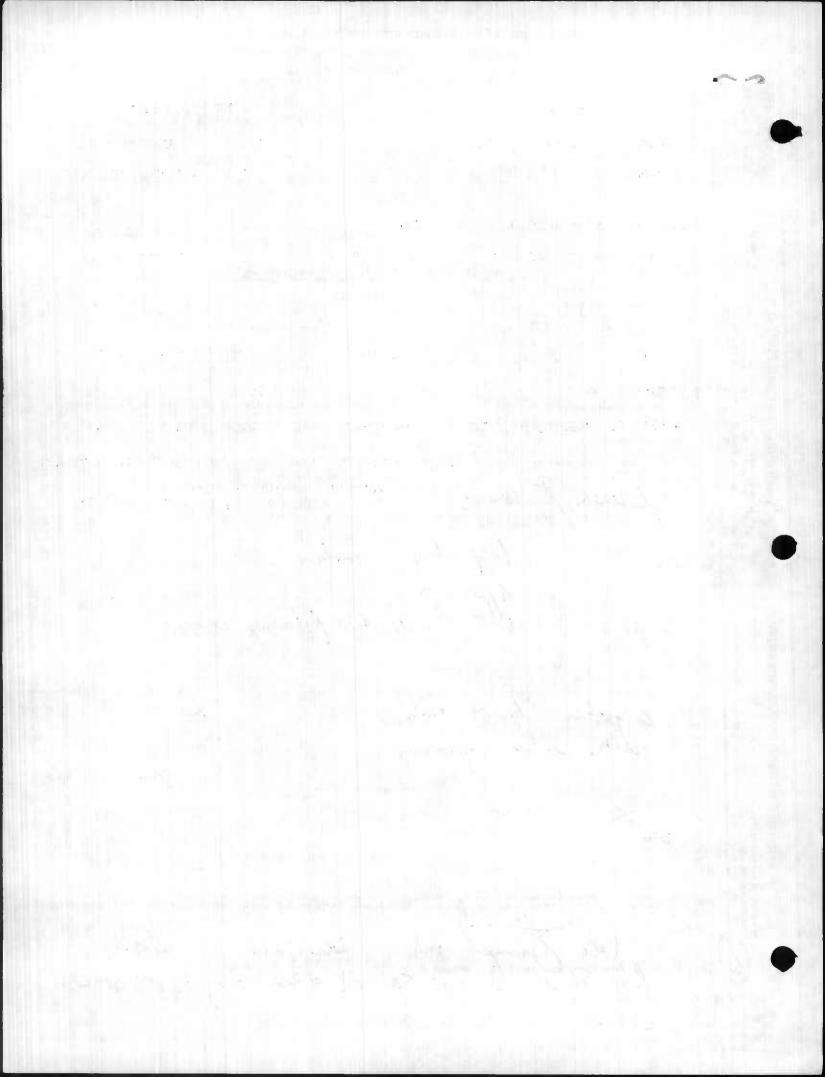
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State of Maryland / Department of Health and Mental Hygiene O

the months of			Certificate	of Death		Reg. No.	
Physician	Decedant's Name (First, Middle, Last)				2. Deta of D Month	Day	Yaer 3. Time of Death
/Medica	LINDY L HALL			# 05 T	JUNE	27, 1999	
Examine	4a Facility Name (If not institution, giva str			40. City, 10	own, or Location of Dea	th 4c. County	of Death
	ANNE ARUNDEL MEDI		est hirthdey) If Under		APOLIS		ARUNDEL
Funeral Director	5. Social Security Number 6. Sex 1 Number 10 N	7. Age (In yrs. I		Deys Hours	Min. (Month, L		9. Birthplace (Stete or Foreign Country) WASHINGTON, DC
show	10a. Stete 10b. County		, Town or Location				10d. Inside City Limits 1 ☐ Yes 💥 ☐ No
ith the Mai	MARYLAND ANNE ARUN	DEL LO	THIAN	and a		10g. Citizan of W	Part Country?
23a or			10f. Zip (11		UNITED	STATES
#1215-0020 within 72 hours efter death with the Maryland ene. than "natural", or items 23a or 28s-4 show the Maryland Energian result be notified at	3 ☐ Widowed 4 ☐ Divorced	Was Decedant Evar in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas:	S. 13. Was Decede It Yas, speci		rigin? (Specify Yas or N n, Puerto Rican, etc.) :		- American Indian, k, Whita, etc. WHITE
re, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours ef thealth and Mental Hygiene. tem 27 is marked other than "natural", or other traumstic event, the Medical Exert To Be Complesed by the	15. Decedent's Educat (Specify only highast grada c	lon ompleted) College (1-4or 5+)	16e. Decedent's Usuel (Give kind of work life. DO NOT use	dona during mo:	st of working	16b. Kind of Bu	siness/industry
d with	12	Oolego (1 401 547	HOMEMAKE	R		OWN	HOME
Iryland 212: hould be filed within to Mental Hygiene. merked other than metic event, the Ir				18. Moth	er's Neme (First, Midd	a, Meidan Sumami	9)
Maryland d 2 should be file h and Mental Hy 7 Is merked oth resumetic event	BANNER LEWIS			ZEN	NA FOSTER		
Taryla 2 should is marken summic	19a. Intorment's Name/Reletionship (Type	, Print)	19b. Meiling Address	Street end Numb	per or Rural Routa Num	ber, City or Town,	Steta, Zip Code)
e, Mart and 2 Health a bm 27 Is	BONNIE R. GRIFFIN,	DAUGHTER	8204 WOBUR	N ABBEY	ROAD, GLEN	DALE MD	20769
ore, Nealth of Health 1 Health 27	20e. Method of Disposition		ace of Disposition (Namemetery, crametory or of	a of	Date		City or Town, State
Page ent o mt: If ry or	1 ☑ Buriai 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donetion 5 ☐ Other (Specify)	novel from Steta	T LINCOLN O		7/1/99	BRENTWOO	OD, MARYLAND
Baltimore, vecil. Pages 1 a portant: If them important: If them important: If them and an other contracts.	21. Signeture of Funeral Service Licensee		22. Nema and	Addrass of Facil		,	
25%	120000 11	uens	3401	BLADENSI	BURG RD. BR	ENTWOOD 1	MD 20722
Physician /Medical Examiner	23a. F. rt1. Enter the disease, of complice hock, or heert teilure. List only one immediate Cause (Finel disease or condition resulting in deeth)	lesprate Due to (or	es e consequence of):	ilure			Intervet Between Onset and Deeth
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Beath atter	Pert II. Other algnificant conditions contril	outing to dooth but not reco	thing in the underlying on	usa shian la Bast	I 23h Di	d tobacco use con	atribute to the cause of death?
that the death certified by the attending detached for usa a	Congestive	heart Fo	Filere	use givairiii r eit		Yes 2□ No	3 Probably 4 Unknown
of Vital Records, P.O. Box Physician: The law requires that the death cent this certificate hes been signed by the attending ral director, page 2 should be detached for usa.	aortic val	re ceptac	cerest			es en eutopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?
Re law		/			10	Yes Dine	1 Yes WNo
	25. Was case referred to medical			26 Plac	ce of Death (Check only	(000)	
Of Vital Re Physician: The I this certificate he ral director, page	examiner?	pital: Inpatient 2 1	ER/Outpatient 3□ DO	Other	ursing Home 5 Ra		er (Specify)
Attending Physic death. ector: After this by the funeral di		28e. Dete of Injury (Month, Dey Year)		c. Injury et Work? 1 Yes 2	28d. Describ	e how injury occurr	
2 9 4 9 E	a Could not be	28e. Plece of Injury - At ho building, atc. (Specify	me, ferm, street, fectory,	office		(Street and Number own, Stete)	er or Rural Route Number,
To the Hospital within 24 hours (to the Funeral Completely filled	29a. Certifier (Check only one) 1 Certifying Physici	an: To the best of my know On the basis of examination	viedge, death occurred a ion and/or investigation,	t the time, date a in my opinion, de	nd place, and due to the ath occurred at the time	e cause(s) and ma e, date and place, a	nner as stated. and due to the cause(s)
To the within 2 Co the	29b. Signature and little of Cortifier	 	29c	License number		29d. Date signed	1 (Month, Day, Year)
	I teles	1115 M	w.	00053	277	6/24	199
(6)	30. Name and ago as of person who are	teted use of death (Item	23a) (Type, Print)	1 # 3	A Annal	elis Mid	1/40)3
State Registrar	31. Dete tiled (Month, Dey, Year)	32. Registrar's Signat	ture	, no	- 1111/4	-1.4	4110

DHMH 16 Rev 6/95



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	Certificate of Death	R	leg. No.	
	1. Decedent's Name (First, Middle, Last)	2. Deta of Dee	th	3. Time of Deeth
Physician	Karl Rudolph Hickerson	Ju1v	Dey 11. 199	Year 9 1:30 pm
/Medical Examiner	4a Facility Name (If not institution, giva street and number) 4b. City, Town, or L		4c. County o	
	104 Canal Street Grasonvi	111e	Oueen	Anne's
Funeral	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Undar 1 Year If Undar 24 Hrs.	8. Date of Birth (Month, Dey		Birthplace (Stata or Foreign Country)
Director	218-16-0197 1M 2 F 77 Yrs. Months Days Hours Min.	May 8,		Washington, DC
fland	10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
filed within 72 hours after death with the Meryland Hygiene. Hygiene. ont, the Medical Examinat must be notified	Maryland Anne Arundel Riva			1 ☐ Yes 2 🛣 No
Dir	10e. Street and Number 10f. Zip Code		log. Citizen of W	het Country?
23 E	2767 Cedar Drive 21140		U.S.A.	
Hems Per Im	11. Marital Stetus 12. Was Decedant Ever in U,S. Amed Forces? 13. Wes Decedent of Hispanic Origin? (St. If Yes, specify Cuban, Mexican, Puerto	pecify Yas or No- p Rican, etc.)		- American Indien, , White, etc.
by by	1 □ Nevar Merried 2 □ Married 1 1 2 Yes 2 □ No If Yes, Give 1 □ Yes 2 1 No Specify: Year or Datas:		Specify:	White
ygiene. Net than "natural", It, the Medical Exa Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of work life. DO NOT use retired)	king	16b. Kind of Bus	iness/Industry
E E	Elementary/Secondery (0-12) Coilege (1-4or 5+)		D-11 A	tlantic
there of the co	8 Communications Worker 17. Fethar's Nama (First, Middla, Last) 18. Mother's Nem	A (First Middle		tlantic
e e e				
To metic		nce V.		
7 is marke trsumatic	19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Ru	rei Route Numbe	r, City or Town, S	State, Zip Code)
225	Virginia June Cahall - Daughter 104 Canal Street, Gra			
or Healt filam 27 r other	20a. Method of Disposition 1 🖾 Burlei 2 Cremetion 3 Removei from State	Date	20c. Location - C	Dity or Town, Stata
		7/14/99	Annapo1	is, Maryland
Important: I any injury o	21. Signeture of Funerel Service Licensee 22. Name and Addrass of Facility			
any and	Gasch's Funeral Hon		++0111	MD 20791
	23a. Part 1. Enter the disease, or compilcations that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart feilure. List only one cause on each line.	or respiretory en	rest.	Approximete
voicion	shock, or heart feilure. List only one cause on each line.			tnterval Between Onset and Deeth
ysician Medical	Immediate Ceuse (Final			
aminer	Immediate Ceuse (Finel disease or condition resulting in death) e. Perputatory Fauleure Due to (or es e consequence of):			
<u></u>	Due to (or es e consequence of): /			
ng isi	b. 608D			
in end rial-transit Examiner	Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury c.			
physician e s the burial- edical Ex				
physicia as the bur edical	rasulting in death) Last Dua to (or as e consequence of):			
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क व	Part II Char significant conditions contributes to doth but not recitive to	92h Did s	ohanno uso so-	tribute to the series of doct.
y the sched	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i.			tribute to the cause of death?
igned by the a be detached to by Physic	Type I Diate Melleles.	101	fes 2□No	3 Probably 4 Tonknown
d b		24a. Wes	an autopsy	24b. Were autopsy findings
should should been si		perfor	med?	available prior to completion of cause
np Pe 2				of death?
Com			ee 20No	1 ☐ Yes 2 ☐ No
s certificate director, pag To Be Co		th Check only or		Daughteric
T dis				Dughter's (Specify) Residence
on on	27. Menner of Deeth 28a. Dete of injury 28b. Time of injury at Work?	280. Dascribe h	ow Injury occurre	90
the f	2 Accidant invastigation M 1 Yes 2 No			
the the	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		or or Rural Routa Number,
P P P				
To the Funeral Directo completely filled in by the Medical Certific	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece (Check only one) Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurrence of the country			
Me Me	29b. Signeture end titia of certifier 29c. Licensa number	- 1	29d. Data signed	(Month, Day, Year)
- 5	1 Refut le G QC 12637.		7//	2/95
(~)		5	///0	-, -,
5/	30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print)		1.	01/01
	Robert M. Greenfield, M.D., 139 Old Solomons Island Rd.	., Annap	olis, MD	21401
State	31. Dete filed (Month, Day, Year) 32. Registrer's Signeture			
Registrar	JUL 1 3 1999 Begins G. Spare			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ysician		Decedent's Nem	e (First, Middle	e, Last)							2. Dete d Month		Day	Year	3. Time of Death
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aminer	40	Facility Neme (111	0	(4b. City, Town,		Death	4c. County		omeny
		MONTO Social Security N		6. Sex	wep,		HOSPI s. last birthday		er 1 Year		rs a Data	f Righ			
eral ctor	5	78-28-19	92		2 ₹ F	. Age (m y/s	75 Yrs.	Months			in. 8. Date of (Month) May	Dey, Ye	1924	Cou	place (Stete or Foreigntry) SVIIIe, V
rector	10	a. Stete	10b. County				City, Town or L Iney	ocation				Т		,	10d. Inside City Limit Yes 2□N
irec	10	e. Street and Nu	mber					10f. Z	ip Code			10g.	. Citizen of V	What Cou	ntry?
a D	2	17513 Pr	incess	Anne	2				20832	2		Un	ited S	State	es.
Examiner must be notified by Funeral Director	5	. Maritai Status 1 Never Marr 3 Widowed		ried	Wes Deced Armed Force 1 Yes 2 if Yes, Give Year or Date	es?	U,S. 13.		edent of Hecify Cuba 2 No	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes of erto Rican, etc	r No-)	Blac	e - Americk, White,	
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		Macon G			ns						lame (First, Mi e Ball	odie, Mai	iden Suman	10)	
5	-	9a. Informant's N					19b Mall	Ing Addre	ss /Street	end Number or		umber. C	City or Town.	State Zk	o Code)
	1	Olga E.						-		ote Rd.					20744
	20	a. Method of Dis	and the second s				Place of Disp	osition (N	eme of	cel	Date	200	c. Location -	City or To	own, State
		1 Burial 2			novel from St	Cl Cl	nesapea				7/13/	99 Be	eltsvi	111e,	Md.
	21	1. Signature of 5	ineral Service	Licens			2	2. Name (and Addre	ss of Facility S. Pop	e Funer	-a1 F	Iomac		
OHER OHER OHER OHER OHER OHER OHER OHER										D. TOP	C Lunci	ar r			
cian ical iner	In di ra	3a. Part . Enter t shock, or hee mmediate Cause issass or condition issulting in death)	(Final			& CHI	ath. Do not en	11315 nter the mo	Loc ode of dyin	kwood D	r. Silv	er S	Spring	1	Approximate interval Between Onset and Death
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A LOUIS CONTRACTOR

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3 Time of Death Month CLAIBORNE M. HARWOOD 7:15 PM アコント 1999 4a. Fecility Neme (If not institution, give street and number) give street and number,

COMMUNITY HOSPITAL

7 Ane (In yrs. last birthday) | If Under 1 Year
| Months | Deys 4b. City. Town, or Location of Deeth 4c. County of Deeth DOCTORS LANHAM PRINCE GEORGES If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yea 5. Sociel Security Number Birthpiece (Stete or Foreign Country) 1**7** M 2□ F Yrs. 578-34-3702 October 4, 1929 Washington, D.C. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Prince George's Lanham 10f. Zlp Code 10g. Citizen of What Country? 5802 Mentana Street 20784 U.S.A. 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Armed Forces 1 1 2 Yes 2 No If Yes, Give Yeer or Detes 1947-1954 1 Never Married 2 Married 1 Yes 2√ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Service Station Owner Auto Repair 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) William R. Harwood Sarah Mangum 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilberte Harwood/Wife 5802 Mentana Street, New Carrollton, MD 20784 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other place) Dete 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Cedar Hill Cemetery 7/13/99 Suitland, MD Signeture of Funeral Service Licera 22. Neme end Address of Fecility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Avenue, Suitland, MD 20746 ul on art. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart valure. List only one cause on each line. Approximate Interval Betw Onset and Deeth e. CORONARY ARTERY

Due to (or es a consequence of): MONTHS DIABETES YEARS Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in douth) Last Due to (or es e consequence of): Due to (or es e consequence of): Part ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 € Unknown 24b. Were autopsy findings aveilable prior to 24e. Wes an eutopsy performed? completion of cause of deeth? 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 6 Could not be 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the cause(s) end menner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chan, M. D.

Physician P.O. Box 68760, Records, of Vital lal or Attanding Physician: The sefter deeth.

al Director: After this certificate ed in by the funerel director, ps Division

The lew requires that the death certificate be

certificate

illed in by

Physician

/Medical

10e Stete

Maryland

10e. Street end Number

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Immediate Cause (Final

disease or condition resulting in deeth)

Examiner

Funeral

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BORN

To the Hospital within 24 hours or To the Funeral Completely filled Hospital State

31. Date filed (Mont nth 10a4 1999

30. Name and address of person who comp

PATRICIA

1 ☐ Yes 2 No 27. Menner of Deeth

1 Naturei 2 Accident

3 Sulcide

29e. Certifier

4 ☐ Homicide

PHAN, M. D. 32. Registrar's Signature

eo cause oi death (item 23a) (Type, Print)

00054228

JULY

DOCTORS COMMUNITY HOSPITAL.

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

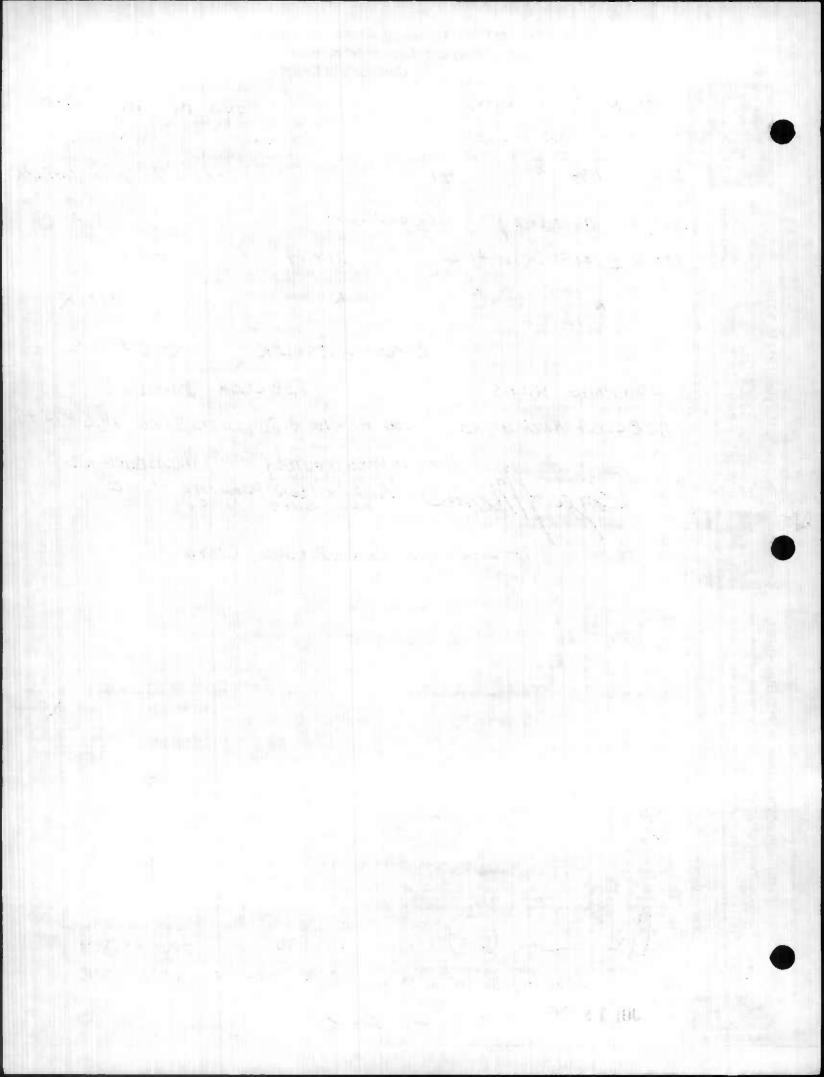
		State of Maryland / Department of Hea Certificate of Department		73.3	ene 9 9	23	805			
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Physic * /Med		JOHN W. HARDY JR.			Dey 11,	Year 1999	5:36PM			
Exam		4a Facility Nema (If not institution, give street and number) 4b. Ci	ity, Town, or Loca	ation of Deeth	4c. County	of Death				
9			CHEVERLY			ce Geo				
Funera		Months Days Ho	Under 24 Hrs. 8 lours Min.	Date of Birth (Month, Day,	Year)	Country	a (State or Foreign			
Director		251-66-5642 ARM 2 F 57 Yrs.		10-2-4	1	S.	.			
5-0020 72 hours after death with the Maryland natural, or Items 23a or 28a-f show dical Examiner must be notified at		10e. Stete 10b. County 10c. City, Town or Location				10d	Inside City Limits			
	To Be Completed by Funeral Director	MD. Prince Georges Takoma Park								
		10e. Street and Number 10f. Zip Code		10	g. Citizen of V	Whet Country	17			
		1614 Drexel Street 20912			U.S.	Α.				
		11. Maritai Status 12. Wes Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispan If Yas, specify Cuban, M	nic Origin? (Speci lexican, Puerto Ri	fy Yas or No- can, etc.)		e - American ck, White, ato				
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72 hours		3 Li Widowed 4 Li Divorced Yeer or Detes: 15. Decedent's Education 18e. Decedent's Usual Occupation	1	1	6b. Kind of B	usiness/Indus	strv			
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ore, Mass 1 and 2 so of Haalth ar (Hem 27 la		19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and It					ode)			
		Diane Hardy/Wife 1614- Drexel St. 20a. Method of Disposition (Name of			Oc. Location -		Ctoto			
		1 YBuriei 2 Cremetion 3 Removel from State cemetery, crematory or other place)								
Baltimoi bemit. Pagas Department of Important: If it any injury or o		4 Donetion 5 Other (Specify) Maryland National C		7/15	Laure	l, Mar	yland			
Baltimo permit. Pag Department Important: I any Injury o		The House of		ams						
_		814 - Upshur 23a. P. 1. Enter the diffesse, or complications that caused the death. Do not enter the mode of dying, su	Street	, N.W.	et		pproximate			
Dhysisian		s lock, or haart failure. List only one cause on each line.	BOTT WES CATCHES OF T	adpiratory arra	51,	Ir	ntervei Between Insat and Deeth			
Physician /Medical	iner	Immediata Cause (Final								
Examiner		disease or condition resulting in deeth) Acute Myocardial Infarction Due to (or as a consequence of):								
D &		Diabetes Mellitus								
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587 icate physis	77	Cause (Disease or injury that initiated events resulting in deeth) Last Dua to (or as a consequence of): d. Part II, Other significant conditions contributing to daeth but not resulting in the undarlying causa given in Pert I. 1 Yes 2 No 3 Probability Probability Yes 2 No 3 Probability Pro								
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of Vita Physician: rthis certific	2	1) Yes 2□ No Hospital: 1□ Inpatient 2□XER/Outpatient 3□ DOA Other: 4	4☐ Nursing Home							
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points ours seral	O E	29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at tha tima, date end piece, and due to the causa(s) end mannar as stated.								
DIVIS To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the	edical	(Check only 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion end mennar steted.								
To the To the comp	Me	29b. Signature and title of certifier 29c. License nur	mber	29	d. Data signe	d (Month, Da	ıy, Year)			
2		D34526	5		July 1	1, 199	9			
(5)		30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)								
0		Casey J. Jason, M.D. 3001 Hospital Drive, Che	everly, 1	Md. 207	85					
	ate	31. Dete filed (Month, Day, Year) 32. Registrer's Signeture								
Regist	rar	JUL 1 4 1999 Server B. Sparks								

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

			Certificate o	t Death	R	eg. No.			
Physician /Medical	1. Decedent's Name (First, Middle, Last	Hicks			2. Date of Deel Month	Day	Year 799	3. Time of Death	
Examiner	4a Fecility Name (If not Institution, give SHOY GLOVE POUNT)	4b. City, Town, or I	or Location of Deeth 4c. County of Death		1607				
Funeral Director	270-78 1178	Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.				Year)	9. Birthplece (State or Foreign Country) FRANK (N CO. A		
H show	Usual Residence of Decedent 10a. State 10b. County MARYLAND Montes		Town or Location	J			10	d. Inside City Limita 1 Yes 2 □ No	
23e or 28e-fust be nours	10e. Street and Number 18030 CHALET	1	10f. Zip Code		10g. Citizen of What Countr		ry?		
ir, or items	11. Merital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,s Armed Forces? 1 Yes 2 No tf Yes, Give Yeer or Detes:		of Hispanic Origin? (Suben, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Bled	e - America ck, White, e	tc.	
tal Hygiene. d other than "nature event, the Medical Be Completed	15. Decedent's Edu (Specify only highest great Elementery/Secondery (0-12)	cation le completed) College (1-4or 5+)	18a. Decedent's Usuel Oci (Give kind of work do life. DO NOT use ref CABLE TIVS	ne during most of wor ired)	king	16b. Kind of Br			
Mental Hygie srked other atic event, tr To Be Co	17. Fether'a Neme (First, Middle, Last)		0.7000	18. Mother's Nen	ne (First, Middle, I	Meiden Sumen	10)		
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this certificate has the rail director, page 2 s	25. Was case referred to medical			26 Place of De	ath (Check only or	nel	1	Yes 2500	
0 E	examiner?	Hospital: 1 ☐ Inpatient 2	€R/Outpatient 3□ DOA	Other:	Home 5 ☐ Residence 8 ☐ Other (Specify)				
the Line	27. Menner of Deeth 1. Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify)		28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, State)					
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he Fund pletely f edical	29e. Certifier (Chapt only only only only only only only only								
Tou	N. C.	mis. (OME) D15236			29d. Dete aigned (Month, Dey, Year)				
(d)	30. Name and address of person who c	ompleted cause of death (Item L) ,		IKE, AO	acvius	-, NO	108	52	



State of Maryland / Department of Health and Mental Hygiene

				Otato or wi	-	ertificate	of Death		Reg. No.	3 2	3807
	Physic /Medi		1. Decedent's Neme (First, Middle, Last	:tt				2. Dete of De Month		Yeer 1999	3. Tima of Death 8, 52 pm
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ı	Funeral Director			x 2□ F 7. Ag	e (In yrs. last birthde Yrs.	Months Do	eer II Under 24 Hrs eys Hours Min.	8. Dete of Bir (Month, De July 20	0, 1921	9. Birthple Count Virg	ece (Stete or Foreign ry) ;inia
	anyland show dat		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town or			<u> </u>		10	d. Inside City Limits
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5-0020	or its	by	11. Meritei Stetus 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Yeer or Detes:		3. Wes Decedent II Yes, specify (ol Hispanic Origin? (S Cuban, Mexican, Puerl No Specify:	pecify Yes or No o Rican, etc.)	14. Race Biec Specify	e - America k, White, e Bla	tc.
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N S	should by and Menta	10	Ed Hiett				Annie R				
Ma	d 2 sho th and 7 la ma trauma		19a. Informant's Name/Relationship (7)				reet and Number or Ru				•
9	1 and Health em 27		Lillie Mae Hiett 20a. Method of Disposition	/ Wife	20h Place of Dis	nosition /Alama o	ton Pl.,SE	Dete Dete	20c. Location -		
Baitimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State		remetory or other ncoln Ce	metery	7/20/99	Brentw		
attii	permit. Page Department of Important: If any Injury or once.		21. Signeture of Juneral Strvice Usens							,	
ä	Depa Impo		+ Tayloon	de	22. Neme end Address of Fecility Johnson & Jenkins, Inc. 716 Kennedy St., NW, Washington, DC 20						20011
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68760,		Medical	resulting in death) Lest		Due to (or es a cons	equence of):		0			0
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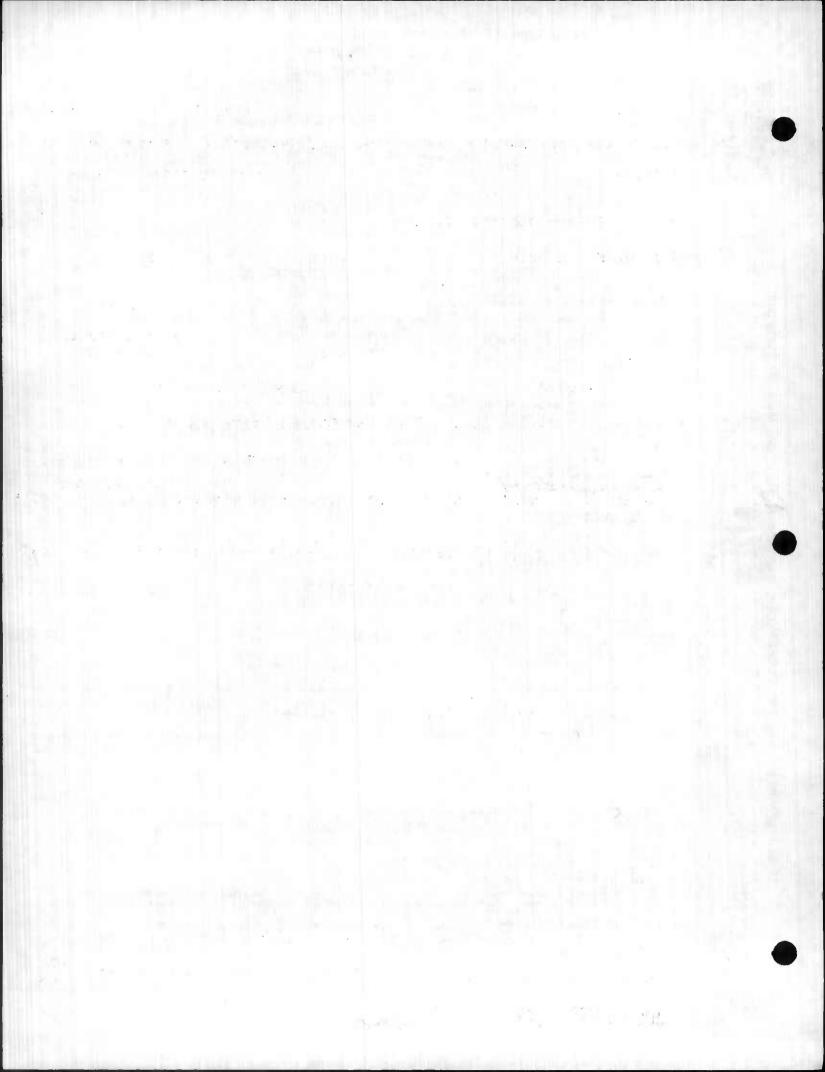
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State Registrar

31. Data filed (Month, Day, Year)

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death FLORENCE HARRIS 1999 JULY 5, 2:10 AM 4b. City, Town, or Location of Deeth 4a Feclity Neme (If not institution, give street end number) 4c. County of Death DENNETT ROAD MANOR NURSING HOME OAKLAND GARRETT 8. Dete of Birth (Month, Dey, Year) If Under 24 Hrs. If Under 1 Yeer Birthplace (Stata or Foreign Country)
 WV 7. Age (In yrs. last birthday) 1 M 2 X F Months Days Hours Min Yrs. 93 AUG 4, 1905 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No PRINCE GEORGES' COLLEGE PARK 10f. Zip Code 10g. Citizan of What Country? 5023 MUSKOGEE STREET 20740 USA 12. Was Decedent Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Yaer or Datas; Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 14 Race - American Indian Bleck, White, etc. 1 □ Navar Marriad 2 □ Married 1 ☐ Yas 2 K No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Dacedant's Education (Giva kind of work done during most of working lifa. DO NOT usa retired) (Specify only highest grade completed) College (1-4or 5+) LPN HEALTH CARE 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Surnama) ELLSWORTH **LONG** AMANDA FLORENCE WILT 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) GEORGE PERRINE - SON 219 ROANOKE AVE. MT. LAKE PARK, MD 21550 20b. Placa of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State GARRETT MEMORIAL GARDENS 7/10/99 OAKLAND, MD

Approximete Interval Between Onset end Deeth

completion of causa of death?

1 ☐ Yas 2 ☐ No

1 Yes 2 No

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Dey, Year)

July 5, 1999

26. Place of Death (Chack only ona)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physiclan /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

7 is merked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Haelth and Mental Hygiene. Important: if frem 27 is marked other than "natural" page.

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REDA

5. Sociel Security Number

10e Street and Number

10a. Stata

Directo

Funeral

by

Completed

217-28-7784

Usuel Rasidence of Dacedant

Elementary/Secondery (0-12)

MICHAEL

20a. Mathod of Disposition

25. Was cesa rafarred to madicel examinar?

29b. Signatura and title of certifiar

5 Panding

Investigation

6 Could not be datarmined

1 Yes ZXXIO

27. Mannar of Death

1 X Natural

2 Accident

3 ☐ Sulcide

29a, Cartifier

4 Homicida

(Check only one)

10b. County

attanding physician and for use as the burial-transit as t esn ed by the a signed by t paga 2 has cartificate director.

After this

s after death.

within 2 To the

à

complately

Medical

or Attending

Hospital 24 hours

the death cartificete be axe

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical 2

Completed Be 10 uneral Certification:

4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Immedieta Cause (Final diseasa or condition rasulting in death) atherosclerotic cardiovascular disease Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immediata ceusa. Enter Underlying Cause (Diseasa or injury that initiated evants rasulting in deeth) Lest Due to (or es e consequence of): Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown atherosclerotic cerebrovascular disease 24b. Wara autopsy findings available prior to 24a. Was an autopsy

30. Nama and addrass of person who completed ceusa of daath (Item 23e) (Type, Print)

Harmer

Hospital:

28a. Data of injury (Month, Day Year)

Walter K. Naumann, M.D., PO Box 247, Accident MD 21520

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Place of Injury - At home, ferm, straat, factory, office building, atc. (Specify)

28b Time of

State Registrar th, Day, Year)





28c. Injury at Work?

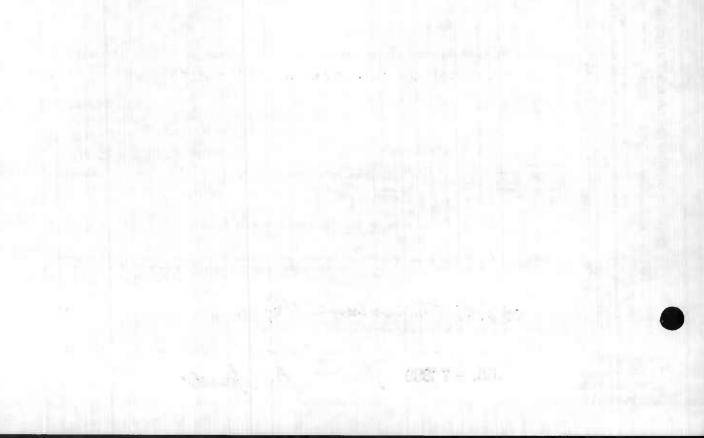
1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, dete and place, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner steted.

D25759

29c. License number

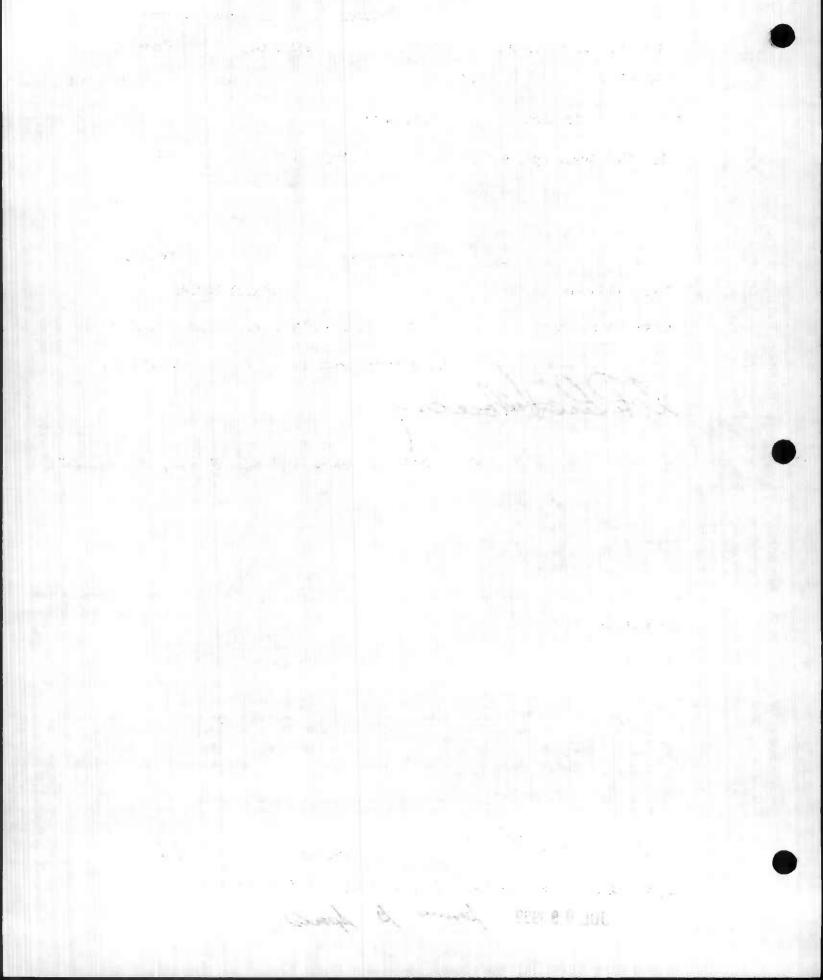
1 ☐ Yes 2 ☐ No



医副二种种医胃性静气 计图点 工工

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23810

		Dogodonii bir.	o (Final Baides 2	0.061							Data of De-	the		3. Time of Death
Physician		. Decedent's Nam	e (FIIST, MIGGIO, LI	#5()						1	2. Date of Dea Month	Day	Year	
/Medical	L.,	LILA					HEA	RNE_			July 7			2:15 AM
Examiner	48	a Facility Name (I									ation of Death			
			. Clearla				1 411		Salis			Wicom		
uneral rector	1	Social Security N 67-20-24 Isual Residence of	70	Sex 1□M 2∑F	7. Age (In yrs		Month	der 1 Year Is Days	If Under 2 Hours	Min.	Date of Birth (Month, De) June 20,		9. Birthpl Count Dela	lace (Stete or Foreig try) Ware
ž		0a. State	10b. County		10c. C	ity, Town	or Location						10	0d. fnside City Limit
Marian Unlanda etor	M	Maryland	Wicom	ico		Salisbury								Mo Yes 2 □ N
and Mental Hygiena. Is marked other than "natural", or items 23a or 28a-f show sumstic event, the Modeal Exerciser must be notified at To Be Completed by Funeral Director		0e. Street and Nur 304 Gle	n Ave.,					Zip Code 2180			10g. Citizen of Whet C USA			
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		15. Decedent's Education (Specify only highest grede completed)				(16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of B	usiness/ind	lustry
		Elementery/Seco	_			or 5+) Homen						Domes		
		7. Father's Name		t)					18. Mother's Name (First, Middle, Melden Sumeme)					
To To		Peter H	lelleso						Ma	rgare	et Butl	er		
E E	1	19a. Informant's Na										r, City or Town,		
7.4		Patsy He	earne/Nie	ce						Dr.	, Salis	sbury, M		
nert of Heelth art: if item 27 liny or other tra		0a. Method of Disp	osition Cremetion 3	Demoved from	20b.	Place of I	Disposition (No., cremetory of	leme of ir other ple	ice)	1	Dete	20c. Location -	City or To	wn, State
important: if it any injury or once.			5 Other (Speci		S	ilver	brook	cook Cemetery 7/9/99					gton,	DE
sician edical miner	la d	23a. Part I. Enter the shock, or hee mmediate Ceuse (disease or condition esulting in deeth)	Final		tastatic	Ade	Penter the m	Elhen						Approximate Interval Between Onset and Death
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death Amended #5 WCHD 7/23/99 cle 2. Data of Death 1. Decedant's Nama (First, Middla, Last) Day Month **Physician** wh 1999 THELMA P. HTCKMAN /Medical 4b. City, Town, or Location of Baath 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 DE 86 Yrs. 214-09-1506 DEC. 11,1912 Director Usuel Rasidanca of Decedant 10a. Stata 10c. City, Town or Location r 28a-f show 10b. County Directo MARYLAND WICOMICO MARDELA SPRINGS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda with r than "natural", or items 23a or the Medical Examiner must be r U.S.A. **502 CHARLES STREET** 21837 Funeral 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status hours after 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas No Specify: Specify: g Widowed 4 ☐ Divorced natural', Hickman Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Hygiene. OWN HOME HOMEMAKER 10 77 is marked other traumatic event, 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Mental WALTER JOHNSON FLORENCE POWELL of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Pages 1 and 2 s mant of Health an LOU ELLEN LAPP 10625 RIVERTON ROAD, MARDELA SPRINGS, MD 21837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata permit. Pages Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) EASTERN SHORE CREMATORIUM 07/09/99 LEWES, DELAWARE 21. Signatura of Funaral Sarvice Licensei 22. Name end Addrass of Facility PARSELL FUNERAL HOMES & CREMATORIUM MO0866 disel 1449 KINGS HIGHWAY, LEWES, DE 19958 2 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. **Physician** Immediata Causa (Final disaasa or condition resulting in daath) /Medical Myolansia LINFANCTION Examiner Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

Box 68760. Division of Vital Records,

attending physician and for use as the burial-transit that the death certificate be axecuted 8 The law requires been s certificate has Physician: this funeral After t or Attending

Physician/Medical

þ

Completed

Be

2

Certification:

rasulting in daath) Last

in 24 hours after death.
the Funeral Director: After the funeral part in by the funeral part in the funeral part in the funeral in the funera completely within 2

State

Medical

31. Data filed (Month, Day, Year) JUL 1 2 1999

25. Was casa refarred to medical axaminar?

5 Panding invastigation

6 Could not be determined

DESMATAIS

1 Yas 2 No

27. Mannar of Death

1 Natural

2 Accident

3 ☐ Suicida

29e. Certifier

4 Homicida

(Check only one)

30. Nama and addrass of parson who complated ceusa of daath (Itam 23a) (Type, Print) 400 EASTERN , M.O. 32. Registrar's Signatura

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

1 Inpetiant

28a. Data of Injury (Month, Day Yaar)

Dua to (or as a consequence of):

Dua to (or as a consequence of):

26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 ER/Outpetient 3 DOA 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Yas 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 1 Cartifying Physician: To the best of my knowledge, death occurred at tha tima, deta end piece, and dua to tha causa(s) and mannar as atated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and mannar stated. 29c. License number 29d. Data signed (Month, Dav. Year) SALISBUIY. SHOVE Dr. mo

24e. Was an autopsy performed?

2 No

3. Time of Death

2220

9. Birthplace (Stata or Foreign

WHALEYSVILLE, MD

WHITE

10d. Inside City Limits

Approximete Intarval Between Onset and Deeth

1-2 DAYS

24b. Wara autopsy findings available prior to

compiation of causa of death?

1 ☐ Yas 2 ☐ No

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

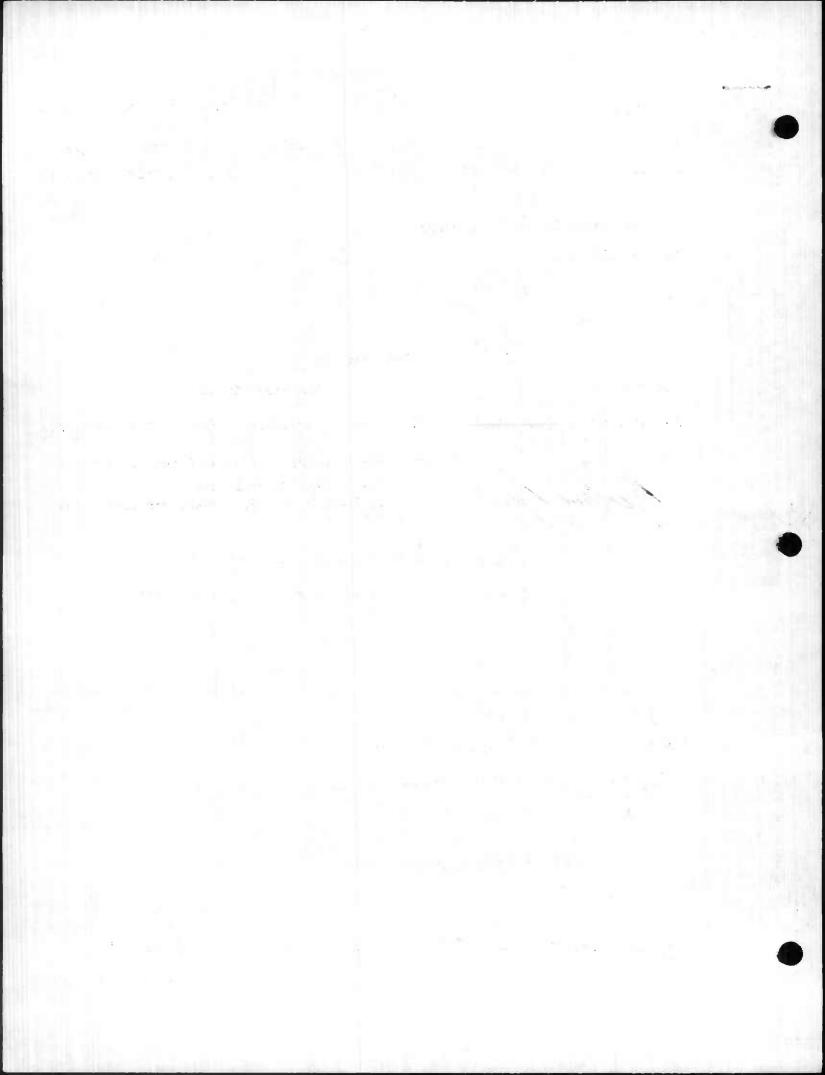
Yas 2 No

WICOMICO

OU 12 1919 Street S Streets

	Amend	#1	9a. Per FH PGC 7-19-99 cr C	ertificate of Death	Reg. N	0.	
	September 197		Decedent's Nema (First, Middla, Last)		2. Data of Death	-	3. Time of Death
	Physic /Medi		EDMUND F. 1221			ey Yeer 9 1999	6:12 PM
	Exami		4a. Facility Neme (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death 4	c. County of Death	
			Doctors Community Hospital	Lanham		Prince Ge	eorges
	Funeral		5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthde	y) If Under 1 Year If Under 24 Hrs. Months Devs Hours Min	8. Data of Birth	0.0146	1000
	Director		080-18-3950 1-∆ M 2 F 72 Yrs. Usuel Rasidance of Decedant		October 2	2 1926	New York
	and **		10a. Stata 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Manylar f ehow	0	Manufacian C				1)∑Was 2□No
	28a-f	Director	Maryland Prince Georges Lanham 10e. Street and Number	10f. Zip Coda	10a, C	itizen of What Cour	ntrv?
	3a or	O E	8500 Magnolia Dr.	20706		U.S.A.	
	death	Funeral	11. Marital Stetus 12. Wes Decedant Evar In U,S. 1	3. Wes Decedant of Hispanic Orlgin? (Spe If Yas, specify Cuban, Maxican, Puarto		14. Rece - Amark	
Maryland 21215-0020	72 hours effer death with the Maryland natural', or flems 23s or 28s-f show of all Examinet must be molified at	by Fu	1 Never Merried 2 Marriad 1 Never Merried 2 Marriad 1 Never Merried 2 Marriad 1 Never Merried 2 Marriad 1 Yas, Giva Yaar or Datas: ₩∏∏	If Yas, specify Cuban, Maxican, Puarto 1 ☐ Yas 2 No Specify:	Rican, atc.)	Black, Whita, Specify: Whi	
0	natural'	be	15. Decedent's Education 16e. De	cedant's Usual Occupation	16b. I	Kind of Businass/In	
215	C . 4	Completed	(Specify only highest grada complated) (Gillife Elamantary/Secondary (0-12) College (1-4or 5+)	va kind of work dona during most of worki n. DO NOT usa ratired)	ing		
21	70 70 1	No.	10	ntelligence	1	NASA	
nd	0 = 0 5	Be (17. Father's Nema (First, Middla, Last)	18. Mother's Name	a (First, Middla, Maida	n Sumame)	
× a		ဂ္	Vincent Izzi	Adalgisa	Simeone		
Var	2 0 0 0		D	elling Addrass (Street and Number or Rura			
	of Health Item 27 other to		Rosemary Boyce (Daughter) 575	Armstrong Ave. Sta			
0	00		LADDING 2 DOTATION 3 DISTRICT STATE	sposition (Nama of rametory or other place)	1000	Location - City or To	
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Ba	permit. Peg Department Important: It any Injury o		21. Signatura of binaral Sarvice Licensea	22. Nama and Address of Facility Rendon/Hale Funer	cal Home		
			flocus / fells	9013 Annapolis Rd	l. Lanham,	Maryland	20706
			23a. Part / Entar tha disease, or complications that caused tha death. Do not a shock, or heart failure. List only one cause on each line.	intar tha mode of dying, such es cardiac o	or respiretory arrast,		Approximate Interval Batween Onset end Death
3	Physician /Medical		Immediata Causa (Final				Onder and Dough
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ds,	requires that the seen signed by th hould be deteche	d by			04-11/	24b 14/	ara autopsy findings
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<u>io</u>	Attending r death. sctor: After by the fune	atic	2 Accidant Invastigation	M 1 Yes 2 No			
Division	r Atterder	Certification:	3 ☐ Suicide 4 ☐ Homicida 6 ☐ Could not be datermined 28a. Place of Injury - At homa, farm, building, atc. (Specify)	streat, factory, office	28f. Location (Street e City or Town, Stat		al Routa Number,
19	ars af	Ce					
0/	To the Hospital or Attend within 24 hours after death To the Funeral Director:, completely filled in by the	edicai	29a. Cartifier (Check only one) Certifying Physician: To the bast of my knowledge, de Medical Examiner: On the basis of examination end/or end manner stated.	ath occurred at tha tima, data and place, a invastigation, in my opinion, daath occurred	and due to tha causa(s ed at the time, dete an	s) and mannar as s nd plece, and dua to	tated. o the cause(s)
	To the Control	Σ	29b. Signature and title of certifiar	29c. License number		ete signed (Month,	Day, Year)
			Effect for my	821883	7	110/99	
			30. Nama and address of person who complated causa of death (Item 23a) (Typ	e, Print)			
			HEMA PYADLAM.D. 947	o ANNAPOLIS Ra	LANH	AM M.	D.20706.
	Sta	to	31. Data filed (Month, Day, Year) 32. Registrar's Signatura		*	-	

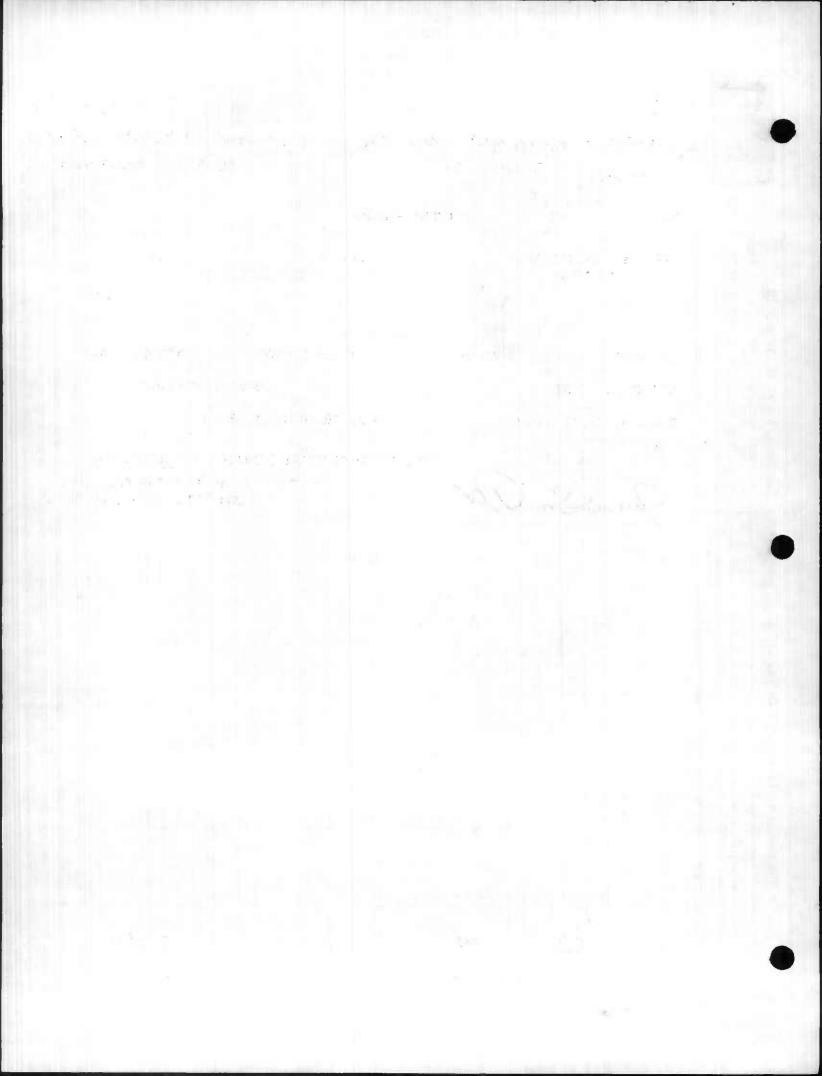
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 23813

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23814 Amend #3.& 18. Per Phys.& FH PGC 7-16-99 cr Certificate of Death Tima of Death 1. Decadant's Name (First, Middla, Last) 2. Data of Death **Physician** VERNON SYLVESTER JANEY 10 Jul /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Lanham Doctors Community Hospital Prince Georges Hours Min. 8. Data of Birth 5. Sociei Security Number If Under 1 Year 7. Aga (In yrs. lest birthday) Birthplace (Stata or Foraign Country) Days 1**™**M 2□F Months 64 215-28-8764 August 14,1934 Maryland Usual Residence of Decedant 10e. Stata 10c. City, Town or Location 10d. Inside City Limita 1 Yes 2 □ No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zin Code 10g. Citizan of What Country? 4303 Dario Road 20772 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 11. Maritai Stetus 14. Rece - American Indian, Biack, Whita, atc. I ☐ Yas 2 💇 No if Yes, Give Year or Datas: 1 Nevar Married 20 Married 1 ☐ Yas 2 No Specify þ 3 Widowed 4 Divorced **Black** Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Coilaga (1-4or 5+) 12th Construction Foreman Private 17. Fathar's Nema (First, Middle, Last) 18. Mothar'a Name (First, Middle, Maiden Surname) 8 Ethel Edith Coates Vernon Sylvester Janey 2 19a. informant'a Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Martha Janey/Wife 4303 Dario Road, Upper Marlboro, Maryland 20772 20b. Piace of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition 07/16 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park Landover, Maryland 1999 21. Signeture of Funaral Sarvice Licenses 22. Nama end Addrass of Facility
J.B. JENKINS FUNERAL HOME Nan Perce 7474 Landover Road, Landover, Maryland 20784 23a. Pert1. Entar tha disease, or complications that ceused the daath. Do not antar tha moda of dying, such as cerdiac or raspiratory arrast, shock, or haert failura. List only one causa on aach lina. Approximate intervei Batw immediata Causa (Final disaasa or condition rasulting in death) Due to (or as a consequence of): 0 Sequentially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Causa (Disaasa or injury that initiated events resulting in daath) Last Due to (or es a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings svallebie prior to complation of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yas 2 ☐ No 25. Was cese rafarred to medical axaminar? 26. Place of Death (Check only one) Hospitai: 1 Yas 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Data of injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. injury at Work? 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide

and -transit that the death certificate be executed physician ar s the bunal-t Box 68760, 88 P.O. been signed by the should be detached Records, page 2 Division of Vital funeral director, this After

Physician/Medical Examiner à Completed or Attending Physician: Be Certification: To To the Rospital or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fun Medical

Funeral

Director

28a-f show

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Home

natural', or

death

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 1 nent of Health and Mental Hygiens.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If Item 27 is marked other than eny Injury or other traumatic event, the Health Injury or other traumatic event, the Health

Physician /Medical

Examiner

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raumatic event, the Medical Examiner must be notified at

31. Data filed (Month, Dey, Year)

11 4 1999 State Registrar

29a. Cartifiar

29b. Signatura and title

29c. Licensa number

🕍 Certifying Phyalclan: To the best of my knowledga, daath occurred at tha time, dete and plece, end due to the causa(s) end mannar as atated. Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29d. Date aigned (Month, Day, Year)

complated cause of deeth (Item 23e) (Type, Print)

50 W. EDMONSTON M.D.

2. Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #10c PER FH G774 8/2/99 AH 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** 1405 pm MAURICE JOHNSON, SR. Tuly 1999 10 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bunker Hill Road, Apt. 106 Cottage City F. y Number 6. Sex 7. Age (In yrs. last birthday) H Undar 1 Year H Undar 24 Ars. 8. Data of Birth (Month, Day, Year) Prince George's 5. Social Security Number Birthplaca (State or Foraign Country) **Funeral** 10X M 2□ F 63 Yrs. 577-52-0932 May 24, 1936 Director Washington, D.C. Usual Rasidence of Decedent the Maryland COTTAGE City 10a State 10b County 10d. Inside City Limits r 28a-f show Maryland Prince George's 1 X Yas 2 No Directo 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? me 23a or death with 4142 Bunker Hill Road, Apt #106 20722 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Year or Datas: 7 is merked other than "natural", or items traumatic event, the Mourcal Examener m Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 11 Mantal Status filed within 72 hours after 100 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16s. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bualness/Industry 15. Decedent's Education (Spacify only highast grada completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Furniture Refinisher Pages 1 and 2 should be filed w frnent of Health and Mental Hygier tant: If frem 27 is marked other th jury or other traumatic event, Its 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middla, Last) Be Charlotte Holmes Raymond Johnson 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tracey R. Johnson/Niece 6921 Woodstream Turn, Lanham, Maryland 20706 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 07/17 1 Burial 2 Cramation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or once. Harmony Memorial Park 4 ☐ Donation 5 ☐ Othar (Specify) 1999 Landover, Maryland 21, Signature of Funeral Service Licansee J.B. JENKINS FUNERAL HOME Percer 7474 Landover Road, Landover, Maryland 20785 a 23a. Part1. Enter the disea or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart faller. List only one cause on each line. **Physician** Arterioscherotic Cardiovaseular Disease /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner certificate be axecuted bunial-transit Bud Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequenca of): physician s the burial Box 68760. Physician/Medical Dua to (or as a consequence of) 98 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mellitus signed t Records. 2 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 ☐ Yes 2 KNo certificate 1 □ Yes 2 □ No. Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Rasidenca 6 Other (Specify) 1 Yes 2□ No 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: After 5 Pending Invastigation 1 Natural 24 hours after death. Funeral Director: Af 1 Tes 2 No 2 Accident

Division of Vital

completaly To the I

Registrar

edical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P11804

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date aignad (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Sylves tea 20

3001 Hospital Drive, Cheverly, Meryland

31. Date filed (Month, Day Year)

6 Could not be

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

Placa of Injury - At homa, farm, straet, factory, office building, etc. (Specify)

P-1

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cian	Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death							43010		
cal .	DELIMA	e (First, Middle, La	A.		JONES		Month JULY		3. Time of De 9 7:15 P	
er	218-48-5866 1□M 2DF			(In yrs. last		4b. City, Town, or L PITTSVIL If Under 24 Hrs. Hours Min.		WICOMI		
	Usual Residence of				our or Location					
2		10b. County			own or Location				10d. Inside City L 1 ☐ Yes 2	
Director	MARYLAND 10e. Street and Nur	WICOMIC	0	PITTS	SVILLE 101. Zip Code			10g. Citizen of Wi	hat Country?	
by rulleral Di		VELLVILLE	RD		2185	n		U.S.		
	11. Meritei Status	ied 2□ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		13. Was Decedent of I		ecity Yes or No Ricen, etc.)	14. Race	- American Indian, , White, etc.	
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	7	William A Riddle A and			HOMEMAKER	do Markada Nasa	- (Final Medala	OWN HO		
1	17. Father's Name (YNE			18. Mother's Nam)	
2	ALGERNOIT			1	9b. Meiling Address (Stree	MANNIE	MITC		State, Zip Code)	
		R. MILLE			5425 POWELLV				MD 21850	
	20a. Method of Disp 1 ☑ Buriai 2 i	position	Removel from Stete	ceme	of Disposition (Name of latery, cremetory or other ple PLEASANT CEMI	ce)	Date 7/15/99	20c. Location - C	City or Town, Stete OS, MARYLAND	
i Examiner	Sequentially list coil any, leading to im	nditions,	b. Hy	ses	e consequence of):				11-	
8	ceuse (Disease or that initiated events resulting in death) I	riying injury	c	Due to (or as	e consequence of):				yes.	
2	ceuse. Enter Unde Ceuse (Disease or that initiated events resulting in death) I	orlying injury Last	d		e consequence of):	ven in Part I.	23b. Did	lobacco use conf	gran.	
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State of Maryland / Department of Health and Mental Hygiene 99 2381

			Certificate of	f Death	Re	g. No.	0 0 1 1		
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Physician /Medical	Lucill	e A. Kaufman			July 1	1999	7:45PM		
Examiner	4e Fecility Neme (If not Institution, give str	eet end number)		4b. City, Town, or Lo		4c. County of			
	3912 Brinkley Road			Temple Hi		1	George's		
Funeral Director	377-36-9173	7. Age (In yrs. les	t birthday) If Under 1 Yee Months Dey		8. Dete of Birth (Month, Dey, Sept. 1		Birthplace (State or Foreign Country) Tazwell, VA.		
*	Usual Rasidence of Decedent 10a. Stete 10b. County	10c. City.	Town or Location				10d. Inside City Limits		
ust be not set at a but a but be not set at a bu	Maryland Prince Geo		ole Hills				1 ☐ Yes 2√2 No		
Dire	10e. Street and Number		10f. Zip Code		10	g. Citizen of Whe	et Country?		
uneral	3912 Brinkley Road		20748			USA			
by Funeral Director	11. Meritei Stetus 12 1 Never Merried 2 Merried 3 X Widowed 4 Divorced	Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 Ano If Yes, Give Yeer or Detes:	13. Wes Decedent of If Yes, specify Cu	f Hispanic Origin? (Spe uban, Mexican, Puerto I o Specify:	Rican, etc.)	Bleck,	American Indien, White, etc. White		
to be	15. Decedent's Educat		16e. Decedent's Usuel Occ	upation	1	6b. Kind of Busin			
Be Completed	(Specify only highest grade c	Collega (1-4or 5+)	life. DO NOT use reti	red)	during most of working				
Con	12th		Homemaker						
To Be	17. Fether's Neme (First, Middle, Last) Lodie Altizer			18. Mother's Nama Carri		Carlo Carlo			
	19e. Informent's Name/Reletionship (Type	, Print)	19b. Mailing Addrass (Stre	et end Number or Rura	il Route Number,	City or Town, Ste	ete, Zip Code)		
, i	Debra A. Kaufman/Da	ughter	Same as ite	em 10					
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Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumatic event, the Manca. To Be Compi	21. Signature of Junerel Service Licensee	11/1	22. Name end Add	Iress of Fecility Kalas Fun	eral Hom	ne. P.A.			
	Bre G. Ko	class	6160 Oxon	Hill Rd.	Oxon Hil	11. MD.	20745		
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ial-tre	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dua to (or a	s a consequance of):						
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To the Funeral Director: After this completely filled in by the funeral director Medical Certification: To	(Check only 2 Medical Examine)	an: To the best of my knowle : On the basis of examination							
To the Funeral completely filled Medical C	one) 29b. Signature and title of certifier	and manner stated.	29c 1 ice	nse number	20	d. Date sinned /	Month, Day, Year)		
F 8	A ALLA COMMISSION) man	1	1285		July 12			
7	genery 4,12	Lecon My) (J) (J	TLON		,			
)/	James A. Brown 970	peted cause of death (Item 2 07 Medical Cer	a)(Type, Print) nter Dr. #300	Rockville	.MD. 208	350			
State	31. Dete filed (Month, Dey, Year)	32 Registrer's Signetur	θ ,		,				
Registrar	JUL 1 3 1999	perer	9. Sport						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 10 Pay JULY, **Physician** 02:25P Kellogg JULI, atherine Marie /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1□ M 2X F Months 216 22 1069 72 Director Sept. 24,1926 Washington D.C. Usual Rasidence of Decedent the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yas 2□ No Director Prince George's Maryland Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 12013 Dove Circle 20708 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ②No If Yas, Giva Year or Datas: 14. Race - American Indian, 11 Marital Status Black, Whita, etc. filed within 72 hours effer 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas ₹ No Specify: Specify: White Aq 32 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Department of Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst Navv 18. Mothar's Nama (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if flem 27 is marked othe eny injury or other traumatic event ables. 17. Father's Nama (First, Middle, Last) Be Richard F. Preusser Katherine Ann Daleiden 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Richard M. Kellogg, Sr. 8707 Oxwell Lane Laurel Maryland 20708 20b. Place of Disposition (Nama of cematary, crematory or other place) July 13, 1999 20a. Mathod of Disposition 20c. Location - City or Town, Stata ¥⊠ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood Maryland 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. 21. Signature of Edneral Service Licenses 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Cause (Final Idiopathic Pulmonary Fibrosis diseasa or conditio rasulting in death) years Examiner Examiner or Attending Physicien: The law requires that the death certificate be executed **Durial-transit** Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): pug Box 68760. physician **Physician/Medical** the th Dua to (or as a consequence of) 80 080 signed by the a 23b. Did tobacco use contribute to the cause of death? Part It. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. Division of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown Hypertension Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1 ☐ Yes 2 ☐ No certificate funeral director. 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital 1 Yes 2No Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 1. Natural 5 Pending 1 Tas 2 No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Clark, M.D. RES-000 gan July 10, 1999 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 116 West University Parkway #434, Baltimore, Maryland 21210 Clark Gregory 32. Registrar's Signetura 31. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

JUL 1 4 1999

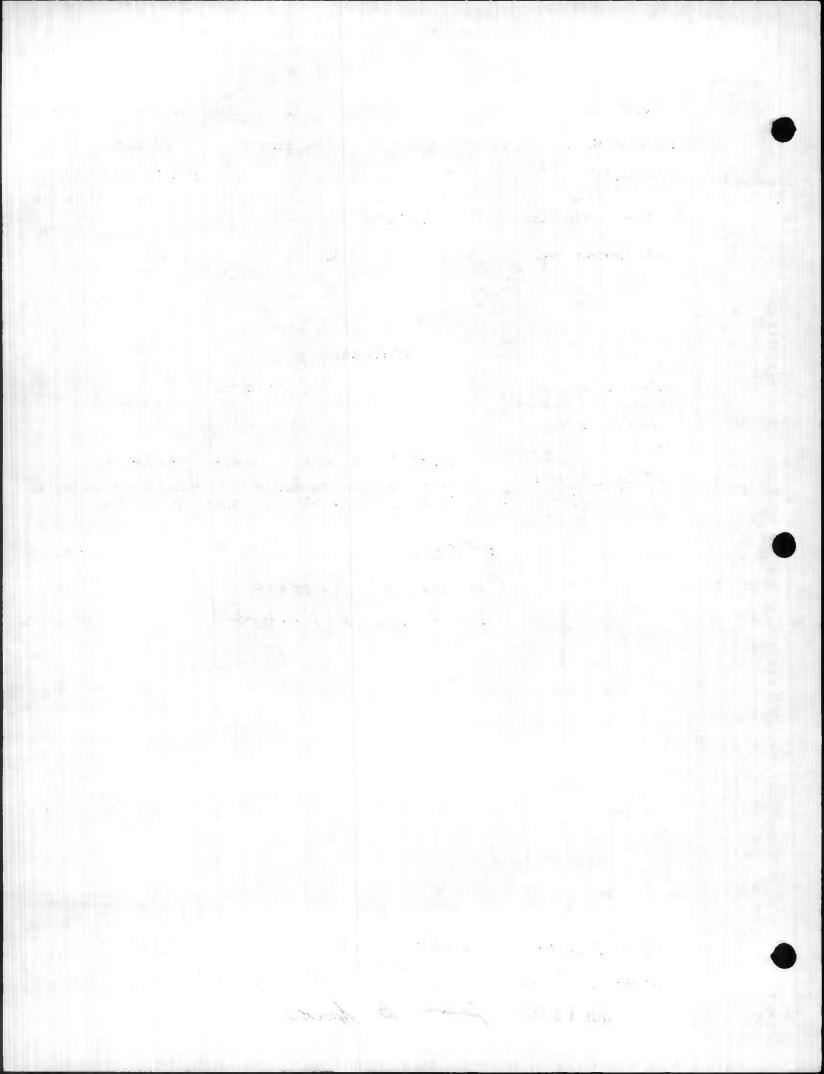
State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** FREDERICK SR. July 13, 1999

4b. City, Town, or Location of Death 4c. County of Deeth В. KREISER 8:20 AM /Medical 4e Fecility Neme (If not institution, give street and number) Examiner Senior Quarters at Chesapeake Landing Salisbury Wicomico If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign Country) **Funeral** Deys Min 1⊠M 2□ F Months Hours 79 Director 203-07-1132 April 24,1920 Pennsylvania the Marylend 10e State 10b County 10c. City. Town or Location 10d. Inside City Limits wode Yes 2 No Maryland Wicomico Directo Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 le merked other than "naturel", or itema 23a or treumatic event, the Medical Examiner must be 1414 Emerson Ave. 21801 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Meritef Stetus Bleck, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried Maryland 21215-0020 1 Yes 2 ℃No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) Clothing Retail Sales Peges 1 and 2 should be filed tent of Health and Mentel Hygi-nt: If item 27 le marked other 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Walter A. Kreiser Lucy Bowers 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Enid Kreiser/Wife Baltimore. 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) Dete 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Pege Department o Important: If i eny Injury or 6 Springhill Memory Gardens 4 ☐ Donetion 5 ☐ Other (Specify) 7/16/99 Hebron, MD in rure of Funerel Service License 22. Name and Address of Facility MOIOSI Holloway Funeral Home Professional Association 23e. Pert1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Interval Between Onset end Death **Physiclan** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner es a consequence of): Examiner certificate be executed physician and s the burial-trans Sequentielly tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Physician/Medical Due to (or es e consequence of): 80 USe ŏ 23b. Did tobacco use contribute to the cause of death? detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o 2 No 3 Probably 4 Unknown 1 Yss signed Division of Vital Records, à 8 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? Completed peen completion of cause of deeth? has page 2 certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certific. A=513/201 LIVE funeral director. 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Be Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Residence 1 Yes 25 No To 28e. Dete of Injury (Month, Dey Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29e. Certifier completely (Check only one) 2 Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. To the Vithin 2 29d. Dete signed (Mgnth, Day, Year) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Healthoury Drive, Salisbury, Md 21884 N. BORODULIA, UD. NICHOLAS 1110

State Registrar 31. Dete filed (Month, Dey, Year)

JUL 1 5 1999

32. Registrar's Signeture



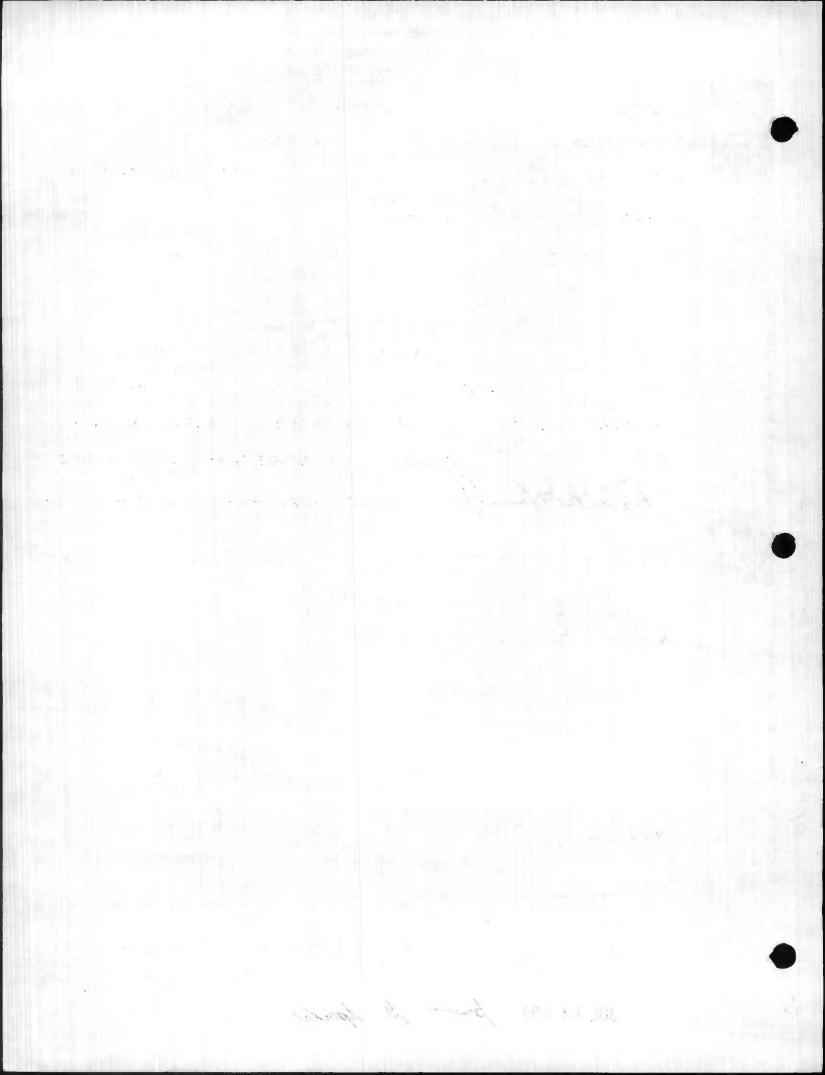
State of Maryland / Department of Health and Mental Hygiene 99 23820

		Certifi	cate of Death	Reg. No.	20020
	Physician /Medical			2. Date of Death Month Day Suly 5 196	3. Time of Death
	Examiner	48 Facility Name (It not institution, give street and number) University of Maryland Medical Syst	Lems Baltimo	2.0	Death Ore City
	Funeral Director		Under 1 Year If Under 24 Hrs. Inths Days Hours Min.	8. Data of Birth 9 (Month, Day, Year)	Birthplace (State or Foraign Country) Nashington, DC
Aerotend	a how	10a. Stata 10b. County 10c. City, Town or Location	n		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
at the	Nome 23e or 28e-f show	MD Wicomico Salisbury 10e. Street and Number 16 1522 Woodkridge Drive	of Zip Code	10g. Citizen of Wha	at Country?
.0020	al, or here 23s more men by Funeral	11. Marital Status 11. Never Married 12. Was Decedent Ever in U,S. Armed Forces? 11. Never Married 12. Was Decedent Ever in U,S. Armed Forces? 11. Yes 2. 2. No	Decedent of Hispanic Origin? (Spe., specify Cuban, Mexican, Puerto Fres 2 2 No Specify:		American Indian, White, etc. White
1215-	han na ban na molete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Usual Occupation of work done during most of workin OT use retired)		ness/industry
0 5				(First, Middle, Maiden Surnama)	ory
rian de pa	Mentel H arked out artic ever		Marie H	ill	
Maryiand	DE E		dress (Street and Number or Rura		
- 5	f Health from 27 other tr	Linda R. Kildea (wife) 1522 Wc 20a. Method of Disposition 20b. Place of Disposition	odridge Drive, S	Date 20c Location - Cit	
Baitimore,	6=5	1 ☐ Burial 2 【XCremation 3 ☐ Removal from Stata cematary, cremator	y or other place)		
	The state of	July 1	na and Addrass of Facility	/9/99 Salisbury	/, MD
n s	on and and and and and and and and and an	Holl 26a. Part1. Enter the disease, or complications that ceur of the death. Do not enter the shock, or heart failure. List only one cause on age.	oway Funeral Hor	me, P.A. Salisbury, MD 21	
E	hysician /Medical xaminer	Immediata Causa (Final disease or condition resulting in death) a. Preumonia Dua to (or as a consequence	se of):		
58/50,		Cause (Disease or injury that initiated events resulting in death) Last C			
TO THE	d by the attending stacked for use and Physician/M	d			
. 0	the at hed for	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23b. Did tobecco use contri	bute to the cause of death?
requires that the	be detaction by Phy			1 Yes 2 No 3	□ Probably → Unknown
9 3	2 20			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	cate ha			Yes 2□No	1 🗆 Yas 2 📉 🗸 🗸
OT VITAI	is certificate director, pag To Be Co		26. Place of Death		
	ith. :: After this o e funeral din efton: To		28c. Injury at Work?	na 5 ☐ Residence 8 ☐ Other (
5 8	4 5 E	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At homa, farm, street, fi building, etc. (Specify)	actory, office 2	8f. Location (Street and Number City or Town, Stata)	or Rural Routa Number,
Hospital	within 24 hours To the Funeral completely filled	29a. Certifier (Check only only) Certifying Physician: To the best of my knowledge, death occur (Check only only) Medical Examiner: On the basis of axaminetion and/or investig and manner stated.	urred at the time, data and place, a lation, in my opinion, death occurre	nd due to the cause(s) and mann id at the time, data and place, and	er as stated. I due to the cause(s)
To the	within To the compl	29b. Signature and title of certifier	29c. License number	29d. Data signed ()	Month, Day, Year)
		I Nichelle Keamm ms	P11775	July &	1999
	12	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Redman MD 22 Soci	th Greene St	pret Balfinon	l.e
	State Registrar	31. Data filed (Month, Day, Year) 32. Registrar's Signature	Son V		

101 0 8 :353 Ess

State of Maryland / Department of Health and Mental Hygiene 9 2382

				Cer	tificate	of	Death			Reg	. No.		
Decedent's Neme (First)	Middle, Last,)							2. Date Mont	of Deeth	Day	Year	3. Time of Death
BEATRICE		E		L	AYFIEI	D			Jul			1997	1:39 4.1
4a Facility Name (If not in:	stitution, give	street end nur	m <i>ber)</i>			_	4b. City, To	wn, or Lo	ocation of	Deeth	4c. County	of Death	
3361 ST. LUK	ES RD.					5	SALIS	BURY			W	ICOMI	CO
5. Social Security Number	6. Se	x	7. Age (In yrs. la	st birthday)	If Under 1	Yeer	If Under	24 Hrs.	8. Date	ol Birth	4	9. Birthp	lace (Stete or Foreign try)
220-09-1584	10]M 2∭F	75	Yrs.	Months	Days	Hours	Min.	AUG.	22.	1923	MARYI	LAND
Usuaf Residence of Deced	ent												
	County		10c. City,	Town or Loc	cation							11	Od. Inside City Limits
MARYLAND W	ICOMIC	0	SAL	ISBUR	Y								1 ☐ Yes 2Ã No
10e. Street and Number					10f. Zip (Code				100	g. Citizen of	What Coun	try?
MARYLAND W 10e. Street and Number 3361 ST. LUK 11. Maritel Stetus 1 Never Married 22	ES RD.					218	304				U.S.A		
11. Maritel Stetus		12. Wss Dece	edent Ever in U,S	i. 13. V	Vas Decede Yes, specif	nt of H	Ispenic Ori	igin? (Sp	ecity Yes	or No-		e - Americ	
1 Never Married 2	Married	Armed Fo 1 ☐ Yes	2KTNo						Rican, et	C.)	Ble	ck, White,	etc.
3 ☐ Widowed 4 ☐ Di	vorced	If Yes, Giv Year or D	/e etes:	1	☐ Yes 2	∐ No	Specify:				Specif	y: WH	ITE
15. De	cedent's Edu	cation		18s. Deced	ent's Usual	Occup	ation			16	6b. Kind of B		
(Specify only Elementery/Secondary (le completed) College (1	I doe 5 ()	18s. Deced (Give I life. D	kind of work OONOT use	done i	du <i>ring</i> mos d)	it of work	ing				
15. De (Specify only Elementery/Secondary (0 12)	сонеде (1		HOUS	EWIFE						OWN H	OME	
17. Fether's Name (First, A	fiddle, Last)						18. Moth	er's Name	e (First, M	liddle, Me	eiden Sumen		
LESTER	J.	AD	KINS				SALL	IE		E.	S	MACK	
19a. Informant's Name/Re				19b. Meilin	g Address	Street			el Route f		City or Town		Code)
JOYCE HOOPER				3004							BURY.		
20a. Method of Disposition		GILLER	20b. Pla	ace of Dispos	ition (Nem	e of		1 10	Dete	-	Oc. Location		
1 ☑ Buriai 2 ☐ Crem	ation 3 🗆 F		Stete	metery, crem	etory or off	er pled		TD3.C					
4 Donation 5 O			SPR	INGHIL					//16	1			RYLAND
21. Signature of Funeral S	ervice Licens	00		22.	Name end	Addre	ss of Facili	ty		/()5 E.	MAIN	51.
bounds funeral Home, INC. SALIS										SALIS	BURY,	MD 21804	
23a. Part 1. Enter the diseashock, or heart feilure	ase, or comp	icetions that c	at ed the deeth.	Do not ente	r the mode	of dyin	ng, such as	cardiac	or respire	lory erres	st,		Approximate tntervsl Between
	,												Onset and Deeth
Immediate Cause (Final disease or condition		D.	ffuse	Land		e 11	1 4		. 1				5 years
resulting in death)	3	a	Due to (or	as a consequ	uence of):		-	Ser 1	-4	~ 9			
Sequentially list conditions if any, leading to immediat cause. Enter Underlying Csuse (Disease or injury that initiated events resulting in death) Last													
Sequentially list conditions		D	Due to (or	as a consequ	uence of):							1	
Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	ė												
Csuse (Disease or injury that initiated events	5	c	Due to (or a	as a consequ	uenca of):	_							
resulting In death) Last			(5)										
		d										<u> </u>	
Part II. Other significant c	anditions oc	ntribution to d-	anth hut not each	ting in the	derbina an	use air	en in Part	1	925	Did tob	acco use co	ntribute to	the cause of death?
Part II. Other significant co	COL	TO DE	ALTERNATION TO SUI	terigriff (file Un	conying ca	use giv	en in rei(230				bably 4 Unknown
										1 🗌 Yaq	2 2 No	3∐ Prol	oeury 4 □ Unknown
AG B									240	Wes en	autonev	24b. W	ere autopsy findings
Ď.									2.70.	perform	ed?	av	ailable prior to mpletion of cause death?
Coupleted												of	death?
									-	1 Ves	2 No	10	☐Yes 2☐ No
25. Was case referred to n	nedical								h (Check				
1 Yes 2 No	1	lospital:	Inpatient 2 E	R/Outpatient	3□ DO/	Oth	ier: 4 🗆 Ni	ursing Ho	me 5	Residen	ica 8 🗆 Ott	her (Specif)	y)
	Pondin-	28a. Dete	of Injury	28b. Time of Injury	28	c. Injur Wor					v Injury occu		
2 Accident	Pending investigation	1,0,011			М		Yes 2□	No					
	Could not be determined	28e. Placa	of Injury - At hon	ne, farm, stre	et, factory,	office				tion (Stre		ber or Rura	I Route Number,
- Homicide		iibliud	ng, etc. (Specity)						Спу	or rown,	Jiele/		
	rtifying Phys	sician: To the	best of my know	ledge, death	occurred a	the tin	ne, date ar	nd place.	end due t	o the ceu	use(s) and m	snner as s	tsted.
(Check only 2 Me		ner: On the ba	asis of examination										
29b. Signeture and title of	certifier	1/	/		29c.	Licens	e number			29	d. Dete signe	ed (Month,	Day, Year)
1 Cot	1	las	T /	n.o.		115-16	306	9 _					
///	1	/											1999
30. Neme and address of p				23a) (Type, i	Print)			//	52		51.	4	MD
Jones E.			M.D.	145	E .	-			27	' /	Delis	-300	,
31. Date filed (Month, Dey,		32. R	egistrer's Signetu	ure &	de.	Pou	(h)		-/-	,	201.5	-300	, MD



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Month Day **Physician** 11:52 PM Charles E. Moore 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner 3936 Sunflower Circle Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthpiece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Deys Hours 1 M 2 □ F Yrs. Director 59 232-62-4181 01-08-1940 Huntington, WVA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If frem 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Mexical Examiner must be norther Pages. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD Prince George's Director Mitchellville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3936 Sunflower Circle 20721 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 [∑Yes 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indian, 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 ☐ Never Merried 2K Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuei Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elamantery/Secondary (0-12) Coilege (1-4or 5+) CPA/Chief Accounting Officer Government 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Emory Polley Lillie Moore Kennedy 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 3936 Sunflower Circle Mitchellville, MD 20721 Joyce Moore/Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Buriel 2 □ Cremetion 3 □ Removal from Stete Washington Natl. Cemetery 7/9/1999 Suitland, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21 Signeture of a laral Service Licensee Tyrone J. Young Funeral Services 719 Kennedy Street, NW Wash., DC shock, or heard feilure. List only one ceuse on each line. 20011 Approximata intervel Between Onset end Deeth **Physician** /Medicai Immediate Cause (Finel disease or condition resulting in deeth) Pancreatic Cancer 3 months Examiner Dua to (or as a consequence of): Examiner physician and s the burial-transit that the death certificete be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): for use as t Po the bed Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by ti 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were eutopsy findings evalleble prior to completion of cause of death? Completed 24a. Was en autopsy performad? s certificate hes t director, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, Be 25. Was casa raferred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Nasidence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 28e. Deta of Injury (Month, Day Year) After 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 Direc 4 Homleida C hours Funeral 156 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and mannar as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, daath occurred et the tima, dete end plece, end due to the cause(s) and manner stated. 29a. Cartifier edical To the 29b. Signature and title of fertifier 29d. Dete signed (Month, Dav. Year) 29c. License number 1999 anne 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) 8926 Woodyard Road Clinton, MD 20735 Harvey T. Katzer, 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture

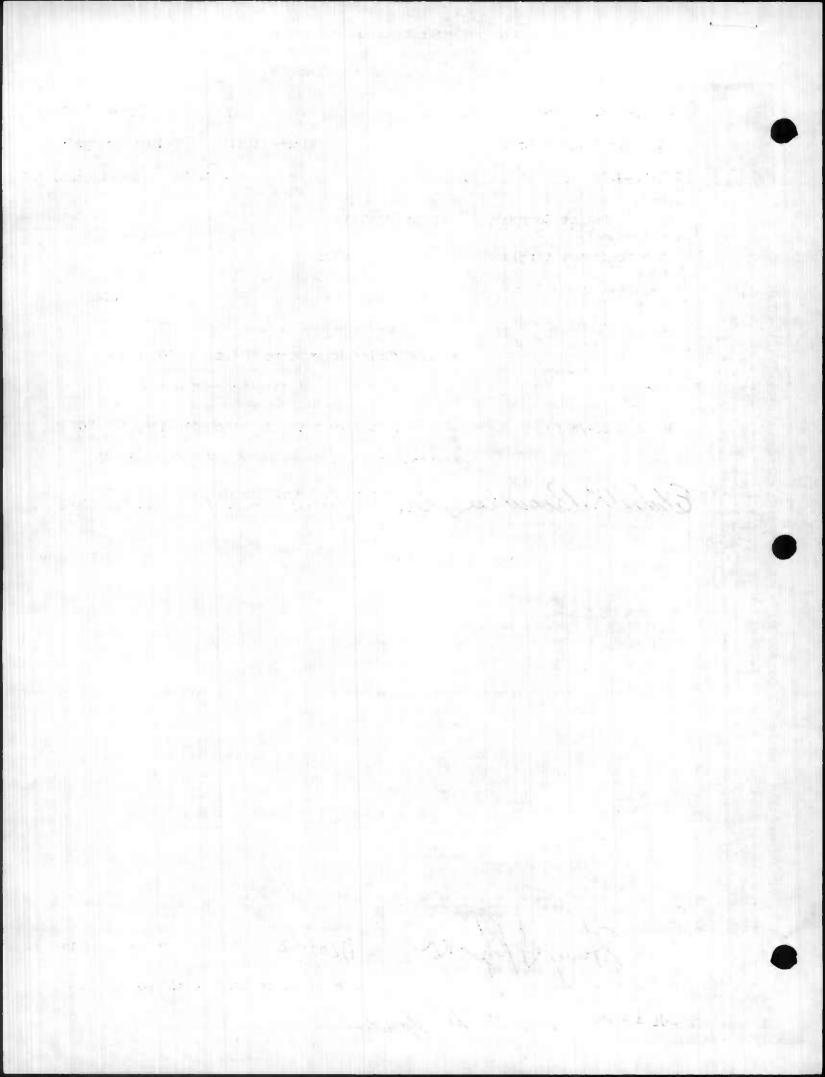
Sparker

DHMH 16 Rev 6/95

State

Registrar

12 1000



State of Maryland / Department of Health and Mental Hygiene RICHARD T. McCAIN AMEND ITEMS: 23 PART I, 27, 28A-F PER MEO G774 8-16-99 WICE CERTIFICATE OF Death

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	-	~	Com	V	0	6-	1

And organization
Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Richard T. McCain 4a Facility Name (If not institution, give street and number)

2. Date of Death Day Month JULY 12, 1999 3. Time of Death 0951 AM

5303 BRENNER STREET 5. Social Security Number

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

4b. City, Town, or Location of Death 4c. County of Death CAPITOL HEIGHTS PRINCE GEORGES

Funeral Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show injury or other treumatic event, the Medical Experies must be notified an endea.

21215-0020

Baltimore, Maryland

212-21-2665 Usual Residence of Decedent

Months 27 Yrs.

Days Hours

8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) December 29, 1971 Maryland

Director

Funeral

by

Completed

Be

10a State 10b. County Maryland

10c. City, Town or Location

10d. Inside City Limits

Prince George's

New Carrollton 10f. Zip Code

XX Yes 2 No 10g. Citizen of What Country?

10e. Street and Number 8437 Ravenswood Road

11. Meritel Stetus 1 Never Merried 2 Merried 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 Who If Yes, Give Year or Dates:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2X No Specify:

20784

14. Rece - American Indien, Bleck, White, atc. specify: Black

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Businass/Industry

Elementery/Secondery (0-12) 12

College (1-4or 5+)

General Contractor

All In One Co.

17. Father's Neme (First, Middle, Last)

Claude McCain

Margaret Boone

19a. Informant's Name/Relationship (Type, Print) Mrs. Angela McCain (WIfe)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8437 Ravenswood Road New Carrollton, Maryland 20784

20a. Method of Disposition

1 XDBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hills Memorial Gardens 7/20/99 Clinton, Maryland

20c. Location - City or Town, Stete

21. Signature of Funeral Service Ligenses

23a. Part1. Enter the orderes, or complete tions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart faill re. Link only one cause on each line.

22. Name and Address of Facility Home, Inc.

4339 Hunt Place, N.E. Washington, D.C.

18. Mother's Name (First, Middle, Maiden Sumame)

Physician /Medical Examine

Examiner

Physician/Medicai

ð

Completed

89

Certification: To

edicai

sician and burial-transit

physician the buria

usa

signed t

certificate Physician:

this funeral

After

the

filled in by

death.

after death

To the Hospital within 24 hours a To the Funeral Completely filled Hospital

The law requires that the death certificate be executed

Box 68760.

P.O.

of Vitai Records.

Division or Attending Immediate Cause (Final disease or condition resulting in death)

SEIZURE DISORDER

Due to (or es a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events that initieted events resulting in death) Last

Due to (or as e consequence of):

Due to (or es a consequence of)

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert 1.

23b. Did tobacco use contribute to the cause of death?

1 Yea 2 No 3 Probably 4 Onknown

24a. Wes en autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Deeth (Check only one)

Approximete Intervel Between Onset and Death

25. Was case referred to medical examiner? XX Yes 2□ No

27. Menner of Death

1 Netural

2 Accident

3 ☐ Suicide

4 | Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) JULY 12, 1999 5 Pending investigation

28b. Time of Injury 9:45 A 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred UNKNOWN

Other: 4 Nursing Home 5 Residence WXOther Section 28d. Describe how injury occurred

29a. Certifier

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) RESIDENCE

28f. Location (Street and Number of Rural Route Number, City or Town, State) 53U3 BRENNER ST. CAPITOL HEIGHTS, MD.

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Chitedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) JULY 13, 1999

HEDDONE MIKE

6XX Could not be

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) State Registrar

1 1999

32. Registrar's Signature

Spork

DHMH 16 Rev 6/95

Physician Funeral Director 28a-f show ò 238 2 should be filed within 72 hours after death vand Mental Hygiene. Is marked other than "neturel", or items 23 Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 a
Department of Health and
Important: If item 27 is ma
any injury or other

Physician

/Medical

Examiner

physician and the bunal-transit

Box 68760

P.O.

Records,

Division of Vital

Completed by Physician/Medical Examiner

Certification: To

Medical

Director

12:05 A.M.

6,1999

J. markley 2. July

1. Decedent's Name (First, Middle, Last) Robert /Medical 4a. Fecility Name (If not institution, give street and number) **Examiner**

Charlotte Hall Veterans Home 5. Social Security Number 1X M 2□ F 287-05-3856 Usuel Residence of Decedent 10b. County Prince Georges Maryland 10e. Street and Number 9750 Wyman Way 1 Never Married 20 Married by 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1X Yes 2 No 1941-If Yes, Give Year or Dates: 70 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Musician

Markley

7. Age (In yrs. last birthday)

83 Yrs.

10c. City, Town or Location

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 ☑ No Specify

14. Race - American Indien, Bleck, White, etc. Specify: White 16b. Kind of Business/Industry

U.S. Air Force

1999

St Marys

4c. County of Death

10g. Citizen of What Country?

USA

17. Father's Name (First, Middle, Last) Jay G. Markley

Elementery/Secondery (0-12)

Ida L. Elzey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

9750 Wyman Way, Upper Marlboro, MD 20772

Jean H. Markley/Wife 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State

19a. Informant's Name/Relationship (Type, Pnint)

4 ☐ Donation 5 ☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Deys

20772

Upper Marlboro

10f. Zip Code

20c. Location - City or Town, Stete 7/10/99 Alexandria, VA

Funeral Service Licepse

22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745

18. Mother's Name (First, Middle, Maiden Sumame)

2. Date of Death

Dec. 27, 1915

Month

July

4b. City, Town, or Location of Death

Charlotte Hall If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heen failure. List only one cause on each line.

3. Time of Death

12:05 am

9. Birthplace (State or Foreign Country)
La Porte, Indiana

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that unitated events resulting in death) Last

e Myoclonic Episode

Due to (or as a consequence of):

Seizure Disorder

Advanced

Parkinson's Disease

Subdural Hematoma

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Valve Reguraitation

onaestive

23h. Did tobacco uses contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

1 ☐ Yes 2 No 26. Piece of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical axaminers 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

27. Menner of Deeth 5 Pending Investigation 1 Natural 2 Accident

28c. Injury at Work? 1 Yes 2 No

29a. Certifier

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signeture and title of certifier

6 Could not be determined

D-45092

29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospita

Registrar

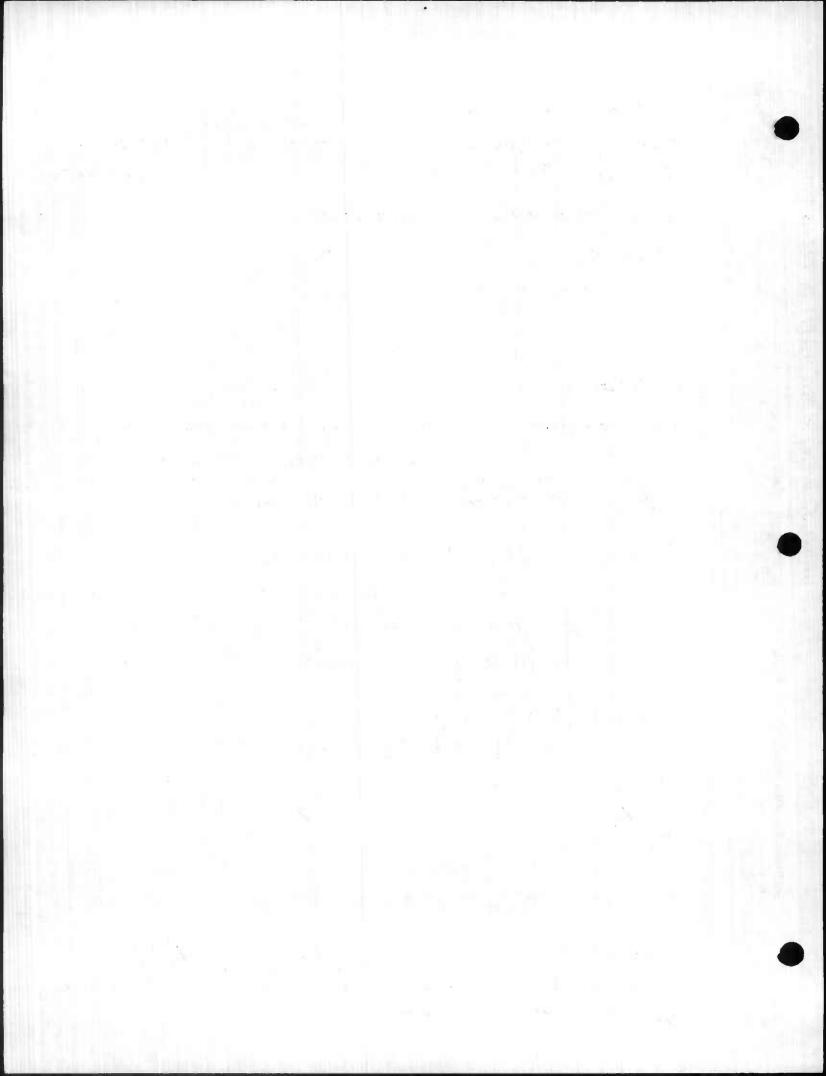
leted cause of death (Item 23a) (Type, Print) Parul S. Jani, M.D.

ad, Suite #204, Prince Fredrick, MD 20678

32. Registrer's Staneture for a first stanet 31. Date filed (Month Day, Year,

the Hospital or Attending Physician:
Dig 24 hours after death.
the Funeral Director: After this certifical mplelely filled in by the funeral director, I

withig 24 hours a
To the Funeral D



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 23825

July

12,

1999

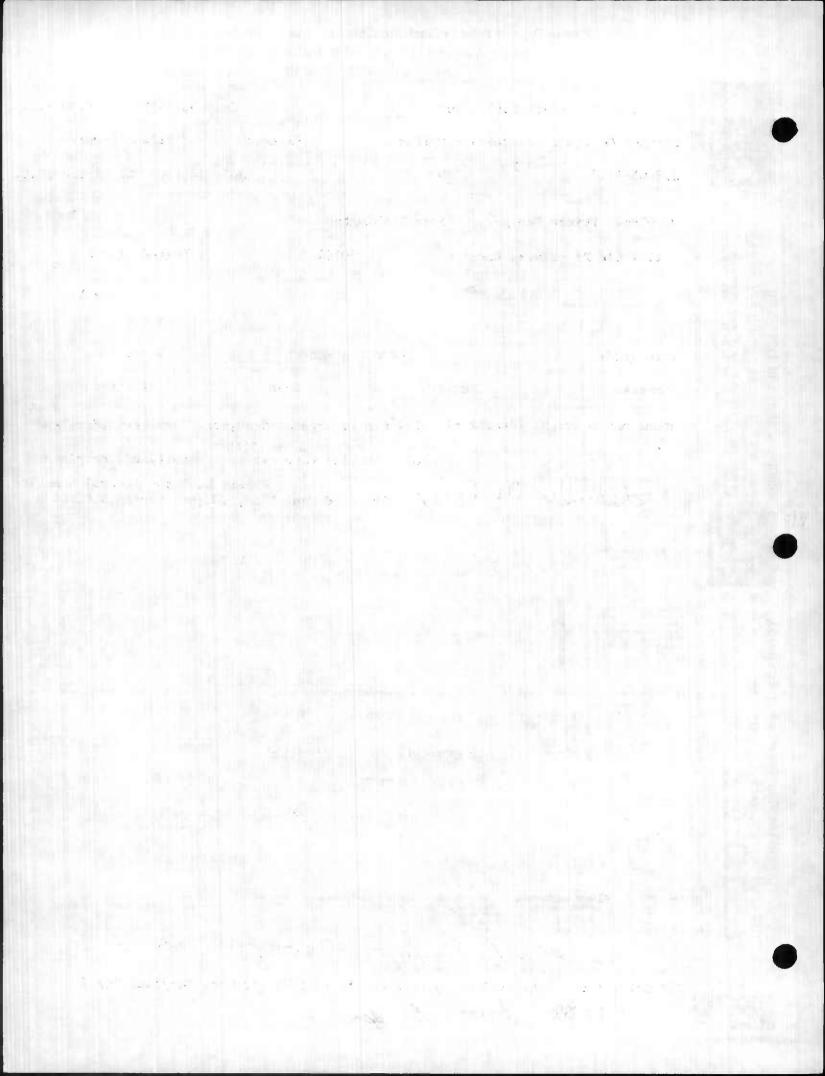
			Certificate	or Death	Reg. N	0.	
	1. Decedent's Neme (First, Middle, La	st)		2	Dete of Death Month De	ey Year	3. Time of Death
Physician /Medical	Hilda Elizabe	th Butler Mus	se			1999	4:50 P.M.
xaminer	4a Fecility Nama (If not Institution, giv	e street end number)		4b. City, Town, or Local	tion of Death 4	c. County of Death	
	Mariner Health of	Southern Man	yland	Clinton	1	Prince Ge	orges
eral ctor	5. Social Security Number 577-05-4124 Usual Rasidanca of Decedant	ax		Deys Hours Min.	Dete of Birth (Month, Dey, Year uly 14,19		plece (State or Foreign ntry) ington, D. C
м	10a. Stata 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
rector	Maryland Prince	Georges I	Fort Washingto	on			1 No 2 No
Director	10e. Street and Number	ocorges 1	10f. Zip Co		10g. C	itizen of What Cou	intry?
5	1217 Old Piscat	raway Poad		744		ited Stat	
67.0	11. Meritel Status	12. Was Decedant Evar in I		t of Hispanic Origin? (Specif		14. Race - Ameri	
by Funeral	1 Never Merried 2 Married	Armed Forcas? 1 ☐ Yes 2 10 No It Yas, Giva Yeer or Datas:	If Yas, specify	Cuben, Mexican, Puarto Ric	can, atc.)	Black, Whita	
Be Completed	15. Decedant's Ed (Specify only highest gre	fucetion	16a. Decedant's Usual C	Occupation	16b. l	Kind of Business/Ir	ndustry
ple	Elementery/Secondary (0-12)	Collega (1-4or 5+)	life. DO NOT use	done during most of working retired)			
E O	12th grade		Domestic			Domestic	
BeC	17. Fathar's Name (First, Middle, Last)			18. Mother's Neme (F	First, Middle, Malde		
P	Charles	Butle	er	Anna		William	18
	19a. informant's Neme/Reletionship (Type, Print)	19b. Mailing Addrass (S	Street end Number or Rural F	Route Number, City	or Town, State, Zi	p Code) 20744
	Ethel Marie Wrigh	nt (daughter)	1217 Old Pi	scataway Road	Fort Was	shington,	Maryland
	20a. Mathod of Disposition		Place of Disposition (Name cemetery, crematory or other	of projece) Tay 15 1	Deta 20c. I	Location · City or T	own, Stata
poce	1 X Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	(Ramoval from State	incoln Memoria			itland, N	Maryland
2000	21. Signature of Funeral Service Licer	m. Cal	. /	Robe od Hope Road,			ral Home,In
ian cal ner	23a. Pert1. Entar tha disaasa, or com shock, or haart failura. List only immediata Causa (Finat diseese or condition resulting in daath)	a. Cons			espiratory arrast,		Approximata intarval Between Onsat and Death
/Medical Examiner	Sequantially list conditions, if any, laading to immediata causa. Entar Indartying Causa (Disease or Injury that initiated evants rasulting in death) Last	C	(or as a consequance of):				
cian							
by Physician	Pert II. Other significant conditions of				1 Tes		to the cause of death obably 4 Unknow
pieted	PRINIPHA	n Vm	ounna	D15 F20062	24a. Was an aut performed?	a	Vere autopsy findings vailable prior to ompletion of cause of death?
Comp	Sastri	cone	irona.		1 🗆 Yes	2 XNo 1	☐ Yes 2☐ No
Be	25. Was case referred to medical examiner?			26. Place of Death /			
2	1 ☐ Yes 2XXNo		☐ ER/Outpatient 3☐ DOA	Other: 4 Nursing Home			eify)
Ë	27. Mennar of Deeth 1.XXIII 5 Panding 2 Accident investigation 2 Could not be		28b. Time of Injury M	Work? 1 ☐ Yes 2 ☐ No	d. Describe how Inj		
d in by	3 Sulcida 6 Could not b 4 Homicida datermined	28e. Place of Injury - At building, atc. (Spec	home, farm, streat, tactory, o sify)	office 28	f. Location (Street and City or Town, Sta	and Number or Ru ate)	rai Route Number,
completely filled in by the funere Medical Certification:		yeiclan: To the best of my kn niner: On the basis of examinend menner stated.					
Me	29b. Signeture and title of certifier	10.//	29c. L	icense number	29d. D	Data signed (Month	n, Day, Year)

State Registrar

Haugh, M.D.; 8926 Woodyard Road, Suite 530; Clinton, Maryland 20735 Patrick

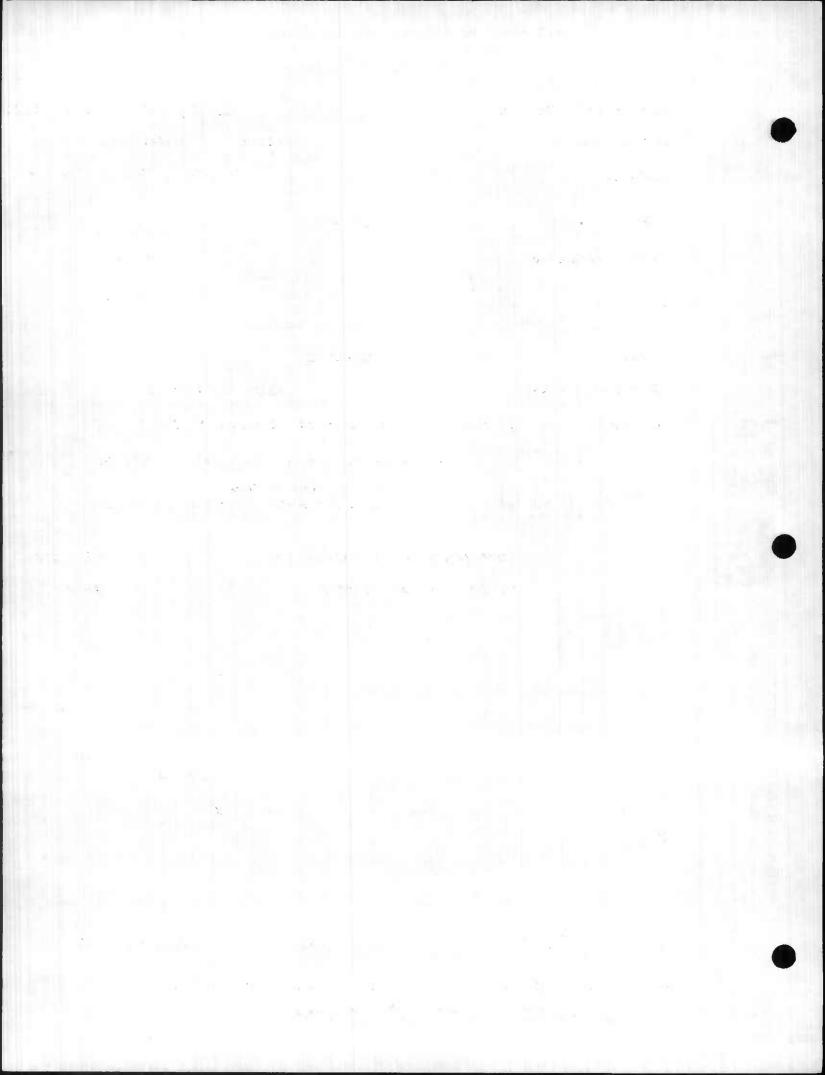
32 Registrar's Signatura

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 23826

								Cen	iiiica	te or	Death			Reg. No.			
			1. Decedent's Nam	e (First, Middle, Li	est)								2. Date of De		Year	3. Ti	ma of Death
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			5. Social Security N	-	Sex	7 400	(In yrs. last b	oieth daul	if Lind	er 1 Yeer	If Under		8. Date of Bir		rett		toto or English
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	h th	Director	10e. Street end Nu	mber					10f. Z	ip Code				10g. Citizen of	Whet Cou	intry?	
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	within 72 hours after death with the Merylend ene. than "naturel", or items 23e or 28e-f show he Medical Examinet must be notified at	Funeral	11. Maritel Stetus	SOLMAN RO	12. Wes De	cedent Ev	er in U.S.	13. W	/es Dec			lgin? (Sp	ecify Yes or No Rican, etc.)	- 14. Ra	S.A.	ican Indi	en,
_	Ter C	5		led 2 Merried	Armed F	Forces?		lf .	Yes, sp	ecify Cuba	an, Mexica	n, Puerto	Rican, etc.)	Ble	eck, White	, etc.	
Maryland 21215-0020	13 a	by	3 🖾 Widowed		If Yes, G	Sive		1	☐ Yes	20[No	Specify:			Speci	fy: Tallh	ite	
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a	Ald the Alent Keed	2	John J	Joseph Ro	wan						1	Alic	e Ameli	a Moon			
a J	2 should be filed within and Mental Hygiene. Is marked other than summit event, the heart		19e. Informent's N	eme/Reletionship	(Type, Print)		19	b. Mailing	Addre	ss (Street	end Numb	er or Ru	ral Route Numb	er, City or Town	, State, Zi	p Code)	
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a l	Heelth Heelth Hem 27 I	1	20e. Method of Dis		arvey/	Daug	20b. Piece	of Dispos	Ition (N	eme of		Vak	Dete Dete	20c. Location		own. Ste	ate
altimore,	ges 1 and 2 should be filed within 72 hours after death with the Menylen it of Heelth and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-f show or other treumatic event, the Medical Examiner must be notified at	- 1		☐Cremetion 3 [Removei from	n State	cemet	ery, crem	etory or	other ple	ce)						
Ē	Pa men ant: ury		4 Donetion	5 ☐ Other (Speci	ify)	_	Whit	te Ch	nurc	h Cer	netery	у	7/10/99	Oaklan	d, MI)	
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ш			shock, or hee	rt failure. List only	one ceuse on	eech line	,									Onset	el Between t and Death
Ш	Physician /Medical		Immediate Cause	(Final													
	Examiner		diseese or condition resulting in death)		e. Acu	te M	iyoca	rdia	1 I	nfai	rctio	on_				Min	utes
			resulting in dealing			D	ue to (or es	e consequ	ience o	f):					1		
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	centificate be executed ding physician and use as the buriel-transit	Examiner	Sequentielly list co	anditions.	D	D	ue to (or es	e consequ	ience of):							
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XO	nding use a	\$			d												
m	tt at o	Physician															
o	that the de ed by the a detached t	18	Pert II. Other signif	licant conditions	contributing to	death but	not resulting	in the un	derlying	cause giv	en in Part	1.	23b. Dld	tobacco use c	ontribute	to the c	suse of death?
0.0	that the ed by th detache	=											1 🗆	Yes 2X No	3 🗆 Pr	obably	4X Unknow
	gne bed	۵	-												1		
5	v requires been sign should be												24e. Wes	an eutopsy ormed?		Vere aut	opsy findings prior to
8	w requ	Completed											pon	01111001	C	ompletic	on of cause
æ	has b	Ĕ												Yes aXINo			
6	cate ha												1	Yes 9KINo	'	⊔ Yes	2 C No
Ë	definer: The	Be	25. Was case refer examiner?	red to medical						-		e of Dea	th (Check only	one)			
of Vital Records,	5 0	9	1 ☐ Yes 212	No	Hospital: 1] Inpatient	2 ER/0	Dutpatient	3□ [OOA Oth	ner: 4□Ni	ursing H	ome 5 X Res	Idenca 6 🗆 O	ther (Spec	ity)	
	offing Ph h. After th funeral	Ë	27. Menner of Deet			e of Injury		. Time of Injury		28c. Injui Wo	ry at rk?		28d. Describe	how Injury occu	irred		
0	ofune e fune	at c	1 M Netural 2 ☐ Accident	5 Pending Investigation				,,	М		Yes 2□	No					
S	or Attending after death. Director: After	Certification:	3 Suicide	6 Could not be determined	28a. Pled	ce of Injury	y - At home,	farm, stre	et, fecto	ory, office				(Street and Num	ber or Ru	ral Route	e Number,
Division	Office In the	ert	4 Homicide	GOLOMINIO	buil	ding, etc.	(Specify)						City or 10	wn, Stete)			
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	To the Hospital of within 24 hours aft To the Funeral Discompletely filled in	edical	29a. Certifier (Check only	1 ☐ Certifying Pl 2 ☐ Medical Exa	miner: On the	basis of e	xaminetion e										ause(s)
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	To the within To the comple	2	29b. Signeture end	Title of certifier	//				2		se number			29d. Date sign			odi j
				1/						D00	3346	4		July 9	1, 1	999	
,	16	1	30. Neme and eddi	ess of person who	completed car	use of dee	eth (Item 23a) (Type, F	Print)								
	4									Q T	20100	T-1	W 267	716			
			31. Dete filed (Mon	M. Cou			's Signeture	U_B	U.A.	V, E	19 101	, V	V 20	10			
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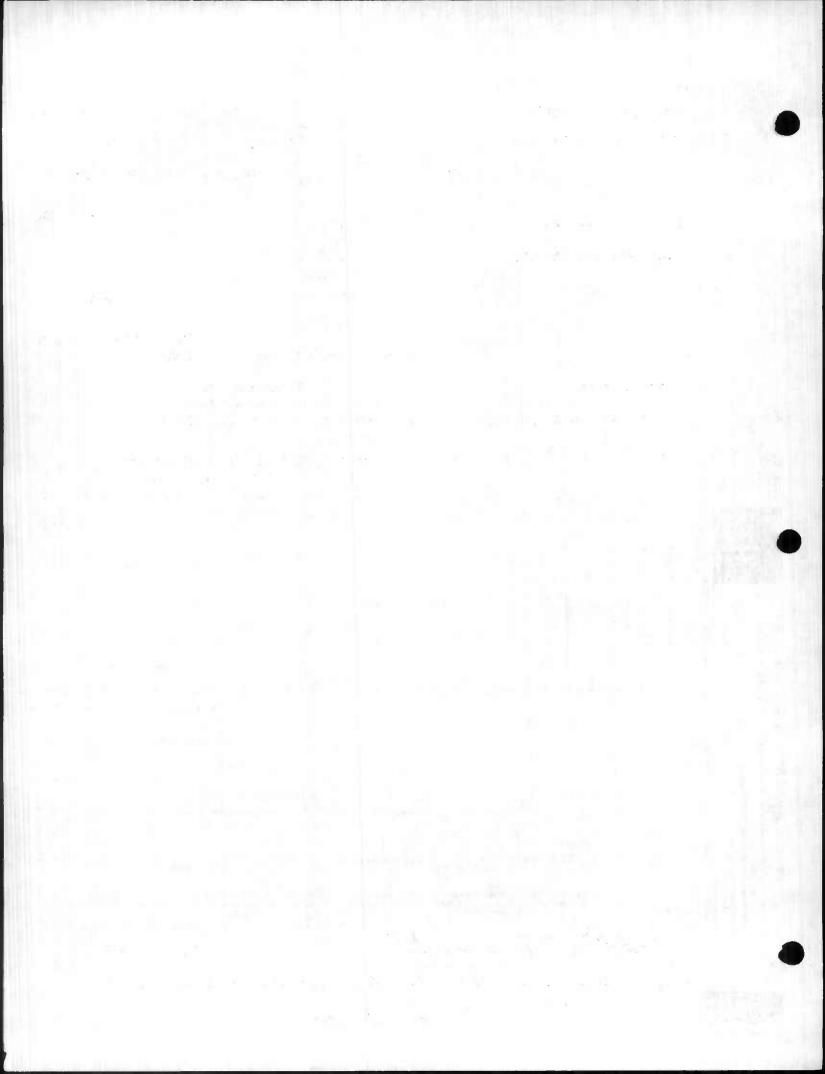


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** Carolyn Long Martin
4a. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth /Medical 4:00 PM Examiner 23364 Garrett Highway McHenry Garrett If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplaca (Stata or Foreign Country) 1□ M 2XF Days Yrs. Director 220-38-2301 57 March 4, 1942 Maryland Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location "natural", or items 23e or 28a-f show 10d. Inside City Limits 1 ☐ Yes 🎎 No Director MD Garrett McHenry 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 23364 Garrett Highway 21541 Completed by Funeral USA filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 1 Never Married > Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White the Medical 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry i Hygiene. Elementery/Secondery (0-12) First United National College (1-4or 5+) 12 Customer Service Rep. Bank & Trust marked other 7 is marked other traumatic event, altimore. Maryland 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) . Pages 1 end 2 should be fill ment of Health end Mental Hant; If Item 27 is marked oth jury or other traumatic even Be Clarence Long Bernadine Edgar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straet and Number or Rural Routa Number, City or Town, Stete, Zip Coda) P. O. Box 538, McHenry, MD Ira J. Martin, Jr./Husband 21541 20b. Place of Disposition (Neme of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Bridgeport Cemetery, July 10, 1999 Bridgeport, WV 21. Signature of Funeral Servica Licensee 22. Name and Address of Fecility Newman Funeral Homes, P.A. 179 Miller St, PO Box 275, Grantsville, MD 21536 curnan 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** immediate Cause (Final disease or condition resulting in death) /Medicai lung cancer 6 months Examiner Due to (or as a consequence of): Physician/Medical Examiner **burial-transit** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): The law requires that the death certificate be exec P.O. Box 68760. use as the Due to (or as e consequenca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detect emphysema 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Deen hes 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical 26. Plece of Death (Chack only ona) 1 Yes 2 No 2 Other: 4 Nursing Home 5 X Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA spital or Attending Phys hours after death. neral Director: After this y filled in by the funeral di this 27. Manner of Deeth Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end mannar as stated.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D25759 anne July 8, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter K. Naumann, M.D., PO Box 247, 106 Cemetery Road, Accident MD 21520 31. Dete filed (Month, Day, Year) JUL - 9 1999 32. Registrer's Signature State Sparte Registrar



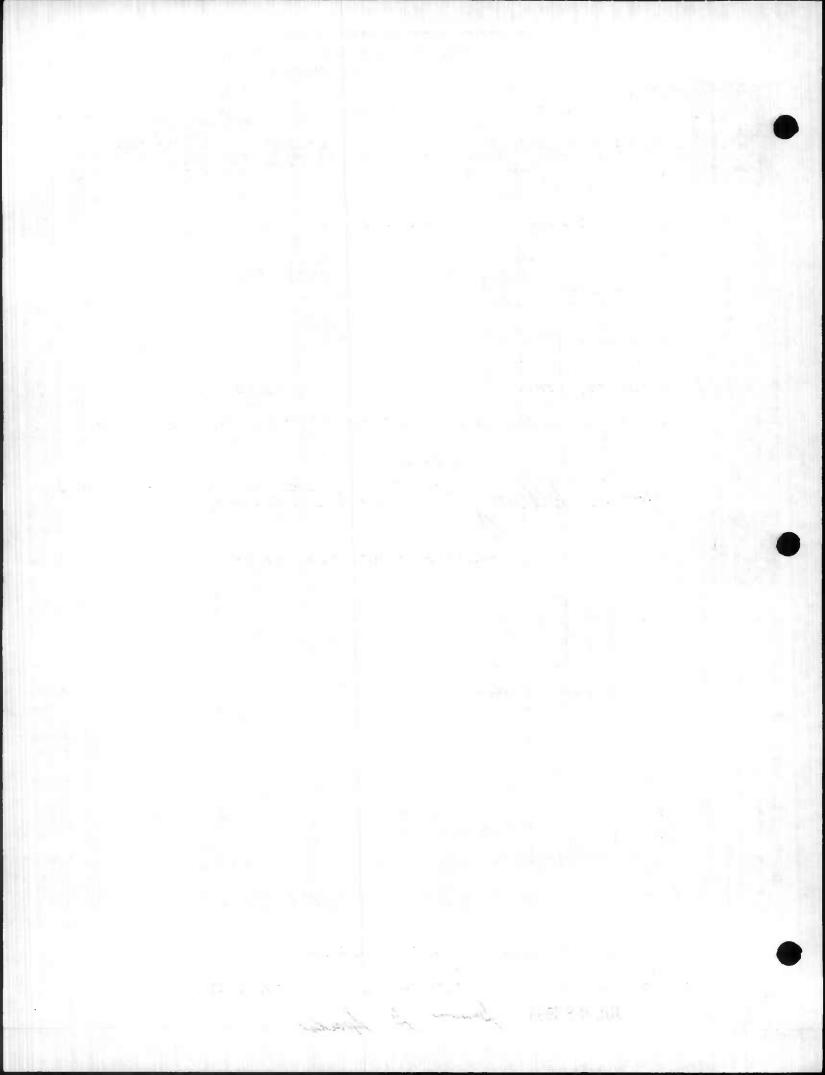
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State of Maryland / Department of Health and Mental Hygiene 99 23828

					Cel	unca	ie or i	Death		F	leg. No.			
	1. [Decedent's Name (First, Middle, La	ist)							2. Date of Dea Month	th Day	Yeer	3. Time of Death	
Physician /Medical	KA	THRYN	E.			MOOR	E			JULY	4 19		8:15 10	
Examiner	4a	Facility Name (If not institution, gir	ve street and numb	er)			4	4b. City, Tov	wn, or Lo	cation of Death	4c. County	of Death		
	6	12 S. DIVISION	ST.					SALI	SBUR	Υ	WI	COMIC	0	
Funeral			Sex 7.	Age (In yrs.	last birthday)		er 1 Year	If Under 2	24 Hrs.	8. Date of Birth (Month, Day		9. Birthplace (State or Country)		
Director	2:	21-28-2046	1□M 2⊠F	53	Yrs.	Months	Days	Hours	Min.				DELAWARE	
	_	ual Residence of Decedent												
ahow stat	108	. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits	
or items 23s or 28s-f short miner must be notified at f Funeral Director	MA	RYLAND WICOMI	CO	S	ALISBU	RY							Y☐ Yes 2☐ No	
be notified Director	10€	. Street and Number		1 0.	101000		ip Code				log. Citizen of	What Coun	itry?	
- E		2 S. DIVISION S	т.				21801				U.S.	Α.		
ler ler	11.	Marital Status	12. Was Decede	ent Ever in U,	S. 13.	Wes Dec	edent of H	lispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		e - Americ		
Funeral		1 Never Married 2 Married	Armed Force						, Puerto	Hican, etc.)	Bia	ck, White,	etc.	
		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes	2X No	Specify:			Specif	WHI	TE	
Completed by		15. Decedent'a E	ducation		16a. Dece	dent's Us	uel Occup	ation			16b. Kind of B	usiness/Inc	dustry	
oje t	-	(Specify only highest gr			(Give	kind of w DO NOT	ork done i use retired	during most	of workli	ng				
E	"	Elemantary/Secondary (0-12)	College (1-4	or 5+)	UPHO	LSTE	RER				OWN	HOME		
Ü	17.	Father's Name (First, Middle, Last	f)					18. Mothe	r's Name	(First, Middle,				
other traumatic event, the Medical El			'NEAL					MARG	ARET	HENRY	SMITH			
5					105 11-11	na A 43-	ne /50			/ Route Numbe		State Tim	Code)	
	1	a. Informant's Name/Relationship				20-23/10-10	1120000000			TOUTE NUMBE	, ony or rown	, Jiere, ZIP	0000)	
		DRRIS L. MOORE -	HUSBAND	201- 0	lace of Dispo			ISION	ST.		BURY, 1			
ò	1 20a	Method of Disposition Method of Disposition Significant	Removal from St		emetery, crea			ca)	1	Date	20c. Location	- City or 10	wn, State	
any Injury o	1	4 □ Donation 5 □ Other (Speci			RINGHI	LL M	EMORY	GARI	ENS	7/7/99	HEBRO	N. MA	RYLAND	
Ē 9	21.	Signature of Funeral Service Lice	nsee /	1				ss of Facilit			705 E.		THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TW	
pace		+0 de	5 /	- 4/										
	22	a. Part1. Enter the disease, or con	polications that cau	end the deat				ERAL I			SALISB	URY	MD 21804	
	20	ahock, or heart failure. List only	one cause on eac	h line.	i. Do not an	ai tira inc	da or dyn	ig, sour as	cardiac c	i respiratory en	idist,	1	Approximata Intarval Between Onset and Death	
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Ä	if a	quentially list conditions, ny, leading to Immediate use. Entar Underlying use (Disease or injury										i		
cai	Ca	t initiated events	C	Due to (o	r as a consec	uence of):							
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3 -			d											
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y Physician	Par	t II. Other significant conditions	contributing to daal	n Dut not res	uning in the u	nderlying	cause giv	ran in Part I.	•				the cause of death?	
7										10	/es 2□ No	3 Pro	bebly 4 Unknown	
by	1-							_				246 161	ara autonou findinas	
te										24a. Was perfo	an autopsy med?	av	ere autopsy findings ailable prior to mpletion of cause	
Completed	-											of	death?	
Eo										101	es 2 No	10	☐ Yes 2☐ No	
9	25.	Was case referred to medical						26. Place	of Death	(Check only o	ne)	1		
ž m		examiner?	Hospital:	ationt OF	ED/Outpatie	at 20.5	Oth	ner:				har /Snacii	(v)	
-		1 Yes 2 No Manner of Death	1 ☐ Inp		ER/Outpatie		NA	4 LI NU	-	me 5 Residence 128d. Describe I			y/	
tlon		1 Panding 5 □ Panding	(Month,	Day Year)	Injury	M	28c. Injur Wor	rk? Yes 2∐i			, , , , , , , , , , , , , , , , , , , ,			
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O	1	4 Homicide datarmined	259. Place of	l injury - At ho , etc. <i>(Specif</i>)	ome, farm, st //	reet, facto	ery, offica			City or Tox		per or Hun	Il Route Number,	
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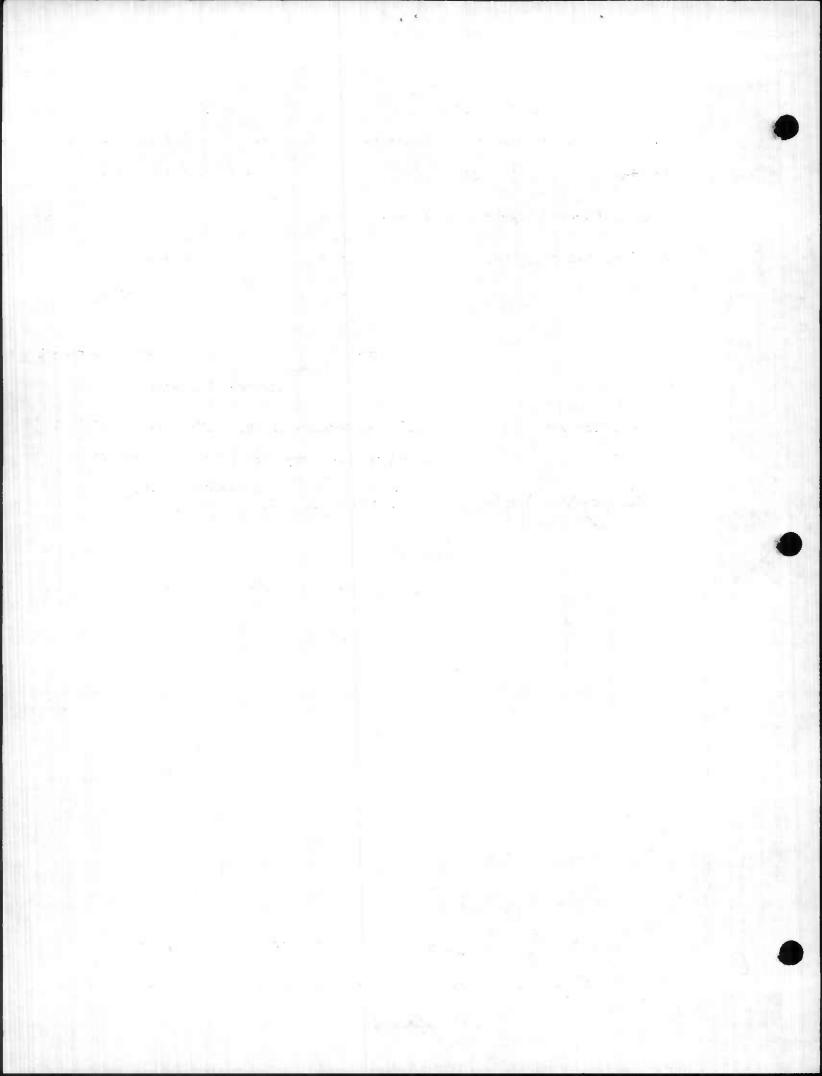
		Decedent's Neme (First, Middle, L.	est)		Cer	TITICAL	e of	Death	2. Dete of De	Reg. No.		Time of Death
hysici					102_				Month	Dey	Yeer	Time of Death
/Medi		HELEN RA 4a. Facility Neme (If not institution, gi	YBURN ve street end number)		MCF	ARLI		4b. Citv. Town, or	07 Location of Deet	h 4c. County		1243
Examir	ier	3881 FIVE FRIARS						SALISBUR				
neral		Social Security Number 6.	Sex 7. Ag	e (In yrs. la	st birthday)	If Under	r 1 Yeer	If Under 24 Hrs	S. 8. Dete of Bir	WICON		(State or Foreig
ctor		429-58-0745	1□M 2対F	64	Yrs.	Months	Deys	Hours Min	December	25,1934	Oklah	noma
		Usuel Residence of Decedent 10a. Stete 10b. County		10c City	Town or Loc	eation					104.4	nside City Limit
	ō	Maryland Wicom	ico									Yes 20 N
	Directo	10e. Street and Number	100		Salisb	10f. Zic	Code			10g. Citizen of V	What Country?	
aner rount be notified at		3881 Five Friar	s Rd			,	2180	Λ		USA		
	Funeral	11. Marital Stetus	12. Wes Decedent	Ever in U,S	5. 13. W	Ves Dece	dent of H	lispenic Origin? (Specify Yes or No	- 14. Rec	e - American Ir	ndien,
	by	1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 4 If Yes, Give Yeer or Detes:			Yes, spe ☐ Yes		an, Mexican, Pue	rto Hican, etc.)		ck, White, etc. v: White	
	Completed	15. Decedent's E			18e. Deced	ent's Usu	el Occup	etion	artina	16b. Kind of B	usiness/Industr	у
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	10	Charles Ralph Ra	-		400 14-712-				Lou Smi			
		Dr. Robert L. Mc		hand					Pu <i>ral Route Numb</i> l., Salis			
		20a. Method of Disposition	CALLETT, ITAL	20b. Ple	ece of Dispos	sition (Na	me of		Dete Dete	20c. Location -		
ODCS.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont			metery, crem	•	•	· .	7/7/99		ury, MD	
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d for use es t	Physician/M		d									
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	by Ph								10	Yee 2627No	3 Probably	4 🗆 Unkno
	Completed									an autopsy ormed?	availeb	utopsy findings le prior to tion of cause n?
eged -						_			10	Yes 2XXVo	1 ☐ Yes	s 2 No
director,	Be	25. Wes case referred to medical examiner?	Hospitel:				Oth		eath (Check only	one)		
9	: To	27. Manner of Deeth	1 Inpatie		R/Outpatient 28b. Time of			4 Li Nursing	Home SAResi	dence 8 Oth		
	Certification:	1 Ablaturel 5 Pending 2 Accident investigation 3 Suicide 8 Could not be	(Month, Da	y Year)	Injury	М		k? Yes 2□No				
		4 Homicide determined	building, et	c. (Specify)					City or To			
	edical		hysician: To the best miner: On the basis of end menner st	examinetic								
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completely filled in		30. Neme and eddress of person who	completed cause of d	7			0035	99		07–06–99)	



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				Clate of Wat		Certificate d	of Death		leg. No.	and has	3030
	Physic	ion	1. Decedent's Neme (First, Middle, Le	ist)				2. Dete of Dee Month	th Dev	Yeer	3. Time of Death
	/Medi		Ruth Be	ernice Nel	son			July 10			5:45 P.M.
	Exami		4e. Fecility Name (If not institution, gir				4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
			Crescent Cities (Center/Genes	sis Eldo		Riverdal		Prince	Georg	ge's
	Funeral Director			Sex 1□M 2Q(F 84	In yrs. lest birth	Months De	er If Under 24 Hrs ys Hours Min.	8. Dete of Birth (Month, Day May 30,	1915	9. Birthple F10r10	ce (Stete or Foreign 1a
	land land		10a. Stete 10b. County	1	0c. City, Town	or Location				100	d. Insida City Limits
	Mary	to	Maryland Prince	George's	Fort V	Vashingtor	ı				1 ☐ Yes 2 No
	r 28s	Director	10e. Street end Numbar			10f. Zip Cod	0	1	l0g. Citizen of \	Whet Country	y?
	3a o		11727 Fort Washir	oton Rd.		207	44		U.S.A.		
Maryland 21215-0020	within 72 hours efter death with the Maryland ene. than "netural", or items 23a or 28a-f ahow he Medical Evanirer must be notified at	by Funeral	11. Meritel Stetus 1 Never Merried 2 Married 3 M Widowed 4 Divorced	12. Wes Decedent Ev. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	er in U,S.		of Hispanic Origin? (Suben, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Red Blee	e - Americar ck, White, et Black	c.
0	2 ho	ted	15. Decedent's E	ducation	18e. C	ecedent's Usuel Oc	cupation ne during most of wo		16b. Kind of B	usiness/Indu	stry
7	within 72 ho ene. than *netur	Completed	(Specify only highest gra Elamantary/Secondery (0-12)	College (1-4or 5+)		ife. DO NOT use rel	ne during most of wo lired)	rking			
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9	be filed that Hygid d other event, th	Be (17. Fether's Neme (First, Middle, Last)				me (First, Middle,		ne)	
N N		2	Dalton Davis				Flor	ence Ca	ldwell		
9	0 2 2		19a. Informant's Name/Relationship	Type, Print)	19b. I	Meiling Addrass (Stra	eet end Number or R	urel Route Numbe	r, City or Town,	Stete, Zip C	Code)
e,	of Heal		Gilbert Nelson/Sc 20a. Method of Disposition 1 Burial 2 X Cremation 3 E 4 Donation 5 Other (Special	Removal from State	20b. Pleca of C cemetery,	727 Ft. Wa Disposition (Neme of cremetory or other) Olitan Cre			20c. Location -	City or Town	n, Stete
	Department Parametricular Important:		21. Signetur of Funeral Service Lice		neti ope	22. Neme end Ad		// 11/ 99	Alexand	IIa, V	1
Ö	permit. Page Department of Important: If any injury or once.		Hears	Halas		George P. 6160 Oxor	Kalas Fu Hill Rd.	Oxon Hi	11. MD	20745	
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00/00	ficate be executed physicien and as the burief-transit	cal Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events	c	a to (or es e co						
	5 0 6	n/Medical	resulting in death) Last	d	e to (or as a co	isoquanca orj.					
	death cer e attendin ed for use	icia	Pert it. Other eignificant conditions of	ontributing to death but r	ot resulting in t	no underlylag agusa	given in Bort I	22h Did to	hacco use co	ndelibuse so si	he cause of death?
	that the ed by th detache	by Physician/M		orninouning to death but I	or resulting in t	re underlying cause	given at reitt.		es 2 No	3 □ Probe	
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110	ysician: The s certificate director, pag	Be	25. Wes case referred to medical exempler?				28. Plece of De	eth (Check only or	ne)		
	5 00	2	1 ☐ Yes 2 ☑ No	Hospitel: 1 ☐ Inpatient	2 ☐ ER/Outp	atient 3□ DOA	Other: 4 Nursing F	lome 5 ☐ Reside	ence 6 □Oth	er (Specify)	
	il or Attending Ph s after death. I Director: After th d in by the funeral	Certification:	27. Manner of Deeth 1 Anaturel 5 Pending 2 Accident Investigetlo		ear) 28b. Tir	ıry V	ijury et Vork? □ Yes 2 □ No	28d. Describe ho			
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	To the Hospital or within 24 hours after the Funeral Director completely filled in	ledical	one) 2 Medical Exam	ysicten: To the best of miner: On the basis of ex end menner steted	emination end/	or Invastigation, In m	y opinion, daeth occu	e, end dua to the corred et the time, d	ause(s) and me eta and place,	nner as stat and dua to th	ed. ne cause(s)
	Somethin Somethin	Σ	29b. Signeture end title of certifier Dep K	Aghon	Zoh	29c. Lice	onse number	2	9d. Dete signe 7 · / /	d (Month, De	ey, Year)
1	(0)		30. Name end eddrass of person who Roger Ingl	completed cause of deet nan 6510 32. Registrer's	Kenilu	orth Ave	. Suite 2	2t00 7	Riverd	ale, i	md.
	Sta	ite	31. Dete filed (Month, Day, Year)	32. Registrer's	Signature					,	
DUIL	Registr		JUL 1 2 1995	givens,	9. Ap	all					

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State of Maryland / Department of Health and Mental Hygiene 9 9 2 3 8 3

					Certifica	ate of E	Death	Rec	. No.		
			1. Decedant's Nama (First, Middla, Last)					2. Dete of Death			Tima of Death
	Physici /Medi		Albert E. Nash					July 9,	Day 1999	Year 1	0:30pm
	Exami		4a. Facility Neme (If not Institution, giva street end	number)		41	. City, Town, or Lo		4c. County	of Deeth	
			Larkin Chase Nursing	Home			Bowie		Princ	e Georg	e's
	Funeral Director		5. Social Security Numbar 6. Sax 1 № M 2 □	7. Age (In yrs. 7.5	Yrs. If Und Month	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y July 1,	(ear) 1924	9. Birthplaca (Country) Washing	Steta or Foreign
	pue *		Usuel Rasidance of Decedant 10a. Stata 10b. County	10c Cif	ty, Town or Location					10d In	side City Limits
	a Maryl Sa-1 sho	Director			ashington,	D.C.					XYes 2 □ No
	th with th		10e. Street and Number 4459 Alabama Ave. S.E.			Zip Coda 20019				/hat Country? States	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show important: if item 27 is marked other than "natural", or items 23s or 28s-f show any halvey or other traumatic event, the Medical Exemine must be noticed at 200s.	by Funeral	1 Naver Married 2 Married 1 Ty	Decedant Evar in Ud Forcas? as 2 No6/12, Giva or Detes: 11/2.	2/44 1 Ves	cedant of His pecify Cuban 2 No	spenic Origin? (Spen, Maxicen, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Amarican Inc k, White, atc.	dan,
5-0	72 hc	eted	15. Decedant's Education (Specify only highast grada complate		16a. Decedant's U (Giva kind of lifa. DO NO)	sual Occupat	tion	16	b. Kind of Bu	sinass/industry	
121	be filed within tal Hyglena. d other than event, he was	Completed		ga (1-4or 5+)					edera:	l Gover	nment
7	iled v tygle ther ti	ပိ	17. Father's Nama (First, Middla, Last)	т	Nuclear R		n Physic 18. Mothar's Name	Ist			
and	od of od of o	Be C	Robert Gaskin Nash					Thornton	wan sumam	a. <i>)</i>	
2	should marke marke	2	19a. Informant's Name/Relationship (Type, Print)		19b Mailing Addre	ass (Street a	nd Number or Rurs		City or Town	State Zin Code	1)
M	and 2 sauth ar n 27 is		Betty N. Stevens/Daug	htor	4445 Alab						
re,	f Hag		20a. Method of Disposition	20b. F	Place of Disposition (fi cematary, cramatory of					City or Town, S	
E O	Pagas nent of I int: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State	rmony Memo		7/	16/99 L	andove	r, Md.	
altimore,	permit. Departmingortal		21. Signature of Funeral Sarvica Licans	na	22. Nama	and Addrass	of Facility				
m	88558		Kitt Augus	M/1081-	Alexa	nder S	S. Pope F	uneral H	omes	1 007/	_
	Physician /Medicai Examiner	er	23a. Panti. Enter the disease, or complications the shock, or heart feiture. List only one cause Immediate Causa (Final disease or condition resulting in death)	Canl	er as a consequence of	10					
	rificata be axecuted ng physician and as tha burial-transit	Examiner	Sequentially list conditions, if any leading to immediate	Dua to (o	or as a consequance of	of):					
68760,	be ay ician buria	aiE	Sequentially list conditions, if any, leading to immediate cause. He thoorying Cause (Disease or injury								
	2 2 8	Medicai	that initiated events resulting in death) Last	Due to (o	r as a consequence o	f):					
Box	daath ce e attandii ed for use	clan	Date Of the Control o					T			
P.0.	that tha daath cended by the attandia	Physician/	Part II. Other significant conditions contributing t	o death but not ras	uiting in the underlying	g ceusa givai	n in Part I.			3 Probably	ause of death? 4 ☐ Unknown
Division of Vital Records,	aw requiras is been sign 2 should be	Completed by						24a. Was an a		24b. Wara au available completi of daath	prior to on of cause
<u> </u>	The ata h	Con						1 □ Yas	2 1 No	1 □ Yes	2 No
/ita	clan: ertific ector,	Be	25. Was cesa rafarrad to medicei axaminer?				26. Place of Death	(Check only ona)			
5	hysle his c	P	1 Yas 2 No Hospital: 1	-	ER/Outpatient 3□		4 Nursing Hor	na 5 🗆 Rasidano			
Z C	ling P	lon:	1 ☑Natural 5 ☐ Panding (A	ata of Injury fonth, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Dascribe how	injury occurr	ed	
Division	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accidant 3 Sulcida 4 Homlcida Investigation Could not be datarmined 28a. Pl	ace of Injury - At ho liding, atc. (Specify	M oma, farm, straat, fact y)		as 2 No	28f. Location (Stre City or Town,		er or Rural Rou	a Number,
	To the Hospital within 24 hours of To the Funeral Completely filled	edical (29a. Cartifier (Check only 2 Medicat Examinar On the	tha best of my kno	wiedga, daath occurre	ed at the time	, data and place, a	and dua to the cou	sa(s) and mai	nnar as stated.	ausa(s)
	the hin 24 the F	Medi	one) and n	annar statad.	morrania intastigati	on, minny opi	mon, dadii occum	7			
	To To Coon	4	29b. Signatura and titla of cartiflet	7.	3	Sec Licansa	1978	290	Data signed	1 (Month, Day,)	rear)
	30)		30. Nama and addrass of parson the completed.	ausa of death (Itan	n 23a) (Tyre) Point)	1	cheve	1/1/ N	1.1	207	185
	Sta	te	31. Data filed (Month, Day, Year)	2. Ragistrar's Signa	itura	-		1-1-			

ACC - M.

DHMH 16 Rev 6/95

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3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** DORTS PAYNE 3, 1999 NOTTINGHAM JULY 2230 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1 □ M 2 🔀 F Yrs. Director 218-12-1283 November 30, 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Wicomico Directo Salisbury 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be r 606 Barnsdale Dr. 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 ☐ Yes 2X No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2X No Specify: 3℃ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) State Government Dept. Social Services 11 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be f Newell William Payne Sue Mason 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health am 27 ly Pamela S. Nottingham/Daughter 606 Barnsdale Dr., Salisbury, MD 21804 Baltimore. 20b. Plece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges Department of I important: If It, any injury or o 1 XBuriai 2 Crementon 3 Removal from Stete
4 Donation 5 Other (Specify) Bates Methodist Cemetery 7/7/99 Snow Hill, MD 22. Name end Address of Facility
Holloway Funeral Home Professional Association 21. Inatu e of Funer Service Licens 501 Snow Hill Rd., Salisbury, MD 21804 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ock, or heart failure. List only one cause on each one. Approximate tnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) SYAG. P /Medical EMBOLIL Examiner Due to (or as a consequence of) Examiner BACTERIAL FNDO VARDITIS SUBAUTTE physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury lhat initiated events resulting in deeth) Last Due to (or as a consequenca of) Box 68760. Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tohacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ISCHEMIL VARDISMYOPATITY Records. g 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed DM, AENAL INSUFFICIENCY. irector, page 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200 No 2 this 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending investigation n 24 hours after death.

• Funeral Director: After letely filled in by the fur 1 ☐ Yes 2 ☐ No 8 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Localion (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner es steted. To the Hosp within 24 hou To the Fune completely fi edicai 2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the cause(s) and manner stated. (Check only one) 29b. Signeture and litie of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) SQUISBUIL mo Chodniche M.D 400 E. SHOPE Dr. Dennis 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State JUL 0 8 1999 Registrar

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death

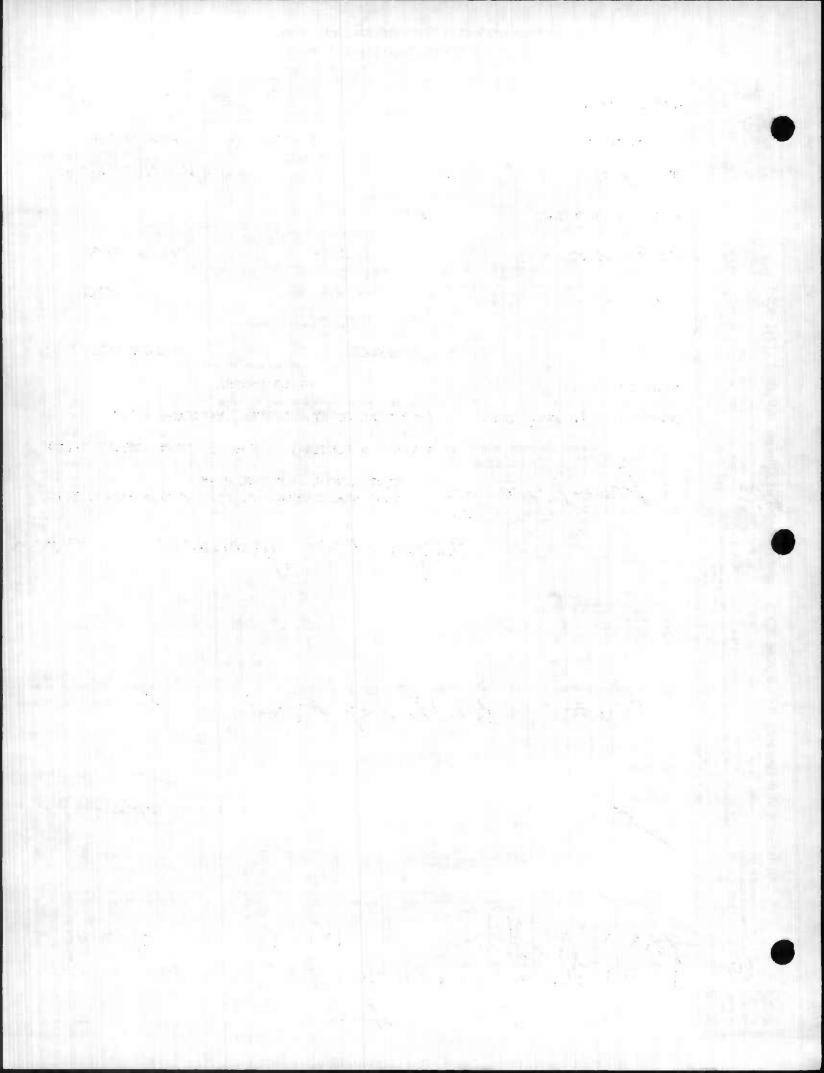
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			,		irtment of the tificate of			F	Reg. No.		
hysician /Medical	1. Decedant's Nama (First, Middle ISABEL PICKREL	e, Last)						JULY	7 D¶¥999	Yaar	3. Time of Death 0036
aminer	4a Facility Name (If not institution	n, give street and nu	mber)					cation of Death			T
ıl	SKYWAY MANOR 5. Social Security Number	6. Sax	7. Age (In yrs. I	ast birthday)	If Under 1 Year	ANNAPC If Under 2			ANNE A		placa (State or Foreign
	577-28-8207	1□M 2 X F	77	Yrs.	Months Days	Hours	Min.	8. Dete of Birth (Month, De) MARCH	y, Year) 30 1922	VIRG	INIA
	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					1	10d. Inside City Limits
ctor	MARYLAND QUEEN	ANNE	CHI	ESTER							1 ☐ Yes 2 🕅 No
Director	10e. Street and Number			-	10f. Zip Code				10g. Citizen of V	What Cour	ntry?
	407 TEAL COURT	40 Wee Day	adent Free in 11		2161		ala? (Cas	naify Vac or No.	UNITED		ES can Indian,
by Funeral	11. Marital Status 1 Navar Marriad 2 Marr 3 Widowad 4 Divorced	Armed Fo	2 □ No ve	'	Nas Decedent of I f Yas, specify Cub I ☐ Yes 2 2 No	an, Mexican	gin? (Spe , Puarto i	Rican, atc.)	Blac	ck, Whita,	atc.
ed ed	15. Deceden				lent's Usual Occu kind of work dona		t of worki	na	16b. Kind of Bu	usiness/In	dustry
Completed	(Specify only higher Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retire	od)	UI WUIKE	'al			
S	1 Z 17. Fathar's Nama (First, Middla,	(agt)		MA	NAGER	18 Motho	r's Name	(First Middle	TELECON Maidan Suman		CATIONS
o Be	MALPH BAUSERMAM	·				GRACI				/	
2	19a. Informant's Name/Relations			19b. Mailir	ng Addrass (Street	1			er, Cify or Town,	Steta, Zip	o Coda)
	CHARLOTTE McDON	ALD-SISTE	R	407 I	EAL COUR	T, CHI	ESTE	R, MARY	LAND 21	619	
	20a. Method of Disposition 1 ■ Burlei 2 □ Cremetion		Stata FOR	iece of Dispo emetery, crer T LINC	sition (Nama of netory or other ple OLN CEME	TERY	7-	Date -9-99	20c. Location - BRENTWO		
	4 □ Donetion 5 □ Other (S				. Name end Addre		v				
edical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if equ, leeding to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a	Due to (or	m	juence of):			reun			Onset and Death,
d by Physician/Me	Part il. Other eignificant condition	d	eath but not resu	ulting in the u	nderlying causa gi	van in Part I	nd	24a. Was	Yee 2 No	3 ☐ Pro	Vere autopsy findings
Completed		•						perfo	rmed?	CI	vailable prior to ompletion of cause I death?
Con								101	Yes 2 No	1	☐ Yes 2☐ No
Be	25. Was case referred to medica examiner?	Hospital:			_ 0	hor:		h Check only o	./	ec.	0000 /11
tion: To	1 Yes 2 No 27. Manner of Death 1 Matural 5 Pendir investi	28a. Date (Mon	-	28b. Time of Injury	28c. Inju	4 U NU		me 5 Resid 28d. Describe I	how injury occur	red	
Certification:	3 Suicide 6 Could determ	not be 28e. Place	of Injury - At ho ing, etc. (Specify	ome, farm, str	aet, factory, office			28f. Location (3 City or Tox	Street and Numi wn, Stete)	ber or Rui	ral Route Number,
edicai	29a. Certifier 1 ertifyin (Check only one) L. Medical	g Physician: To the Examiner: On the and ha	best of my know asis of examinat ner stated.	wiedge, deati	vestigation, in my	opinion, dae	d place,	end due to the	date and place,	and due I	to the cause(s)
2	29b. Signature and title of certifie	X	Aun		29c. Licen	very see number	38		29d. Date signa	(Month)	199
	O. Nama and address of per op	A B	of death (Item	23a) (Ppe.	Print) of	AF	57	61W	ANN	por.	Morney

Registrar

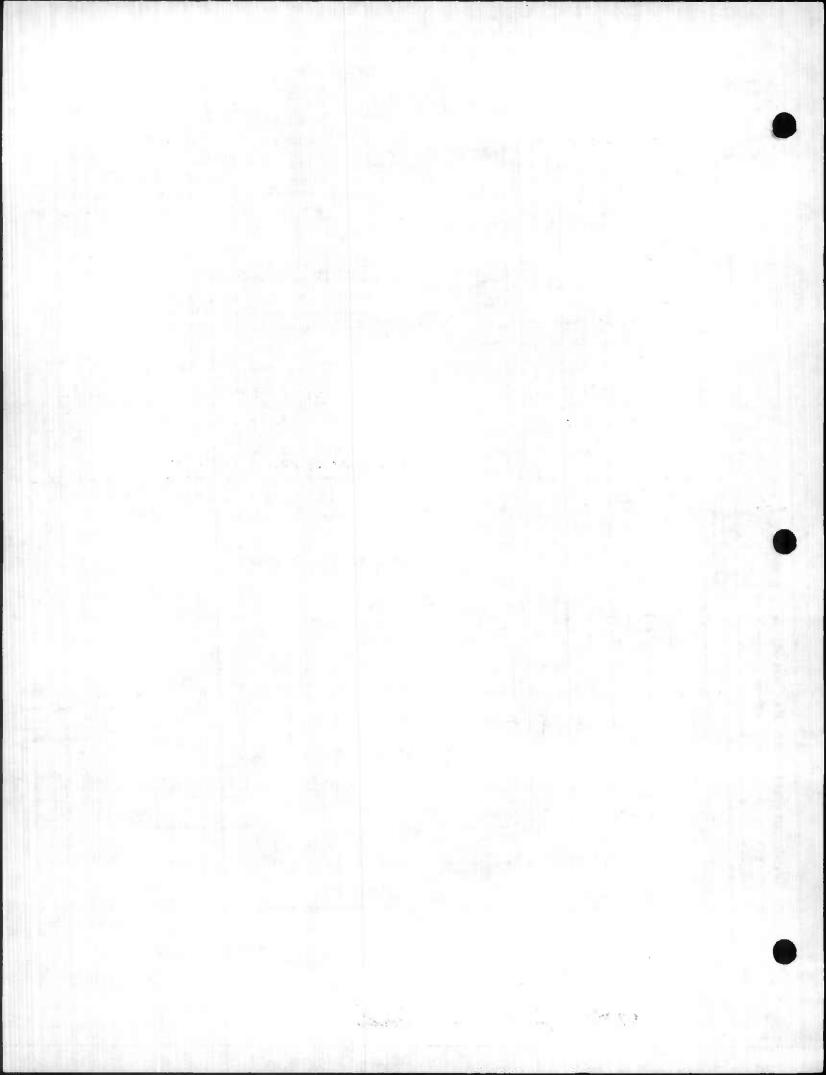


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State of Maryland / Department of Health and Mental Hygiene 23834 Certificate of Death Rea. No. 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Potts Month Day **Physician** Gladys Schellin 1999 0905 エレノマ 9 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Longview Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. July 8, 1915 9. Birthplaca (Stata or Foreign Country) Georgia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2IXF Months Yrs. 84 Director 578-44-8276 Usual Residence of Decedent the Maryland 10s State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or heme 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 XX Directo Maryland Carrol1 Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4641 Water Tank Road 21102 U.S.A. Funeral death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, mit. Pages 1 and 2 should be filled within 72 hours after continuous of Health and Mental Hygiene.
Important: if Nem 27 is marked other than "natural", or here any injury or other traumatic event, the second of the page. Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates: Black, Whita, atc 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No white Specify Specify: p XXX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Branch Chief/Census Bureau 12 U. S. Government 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) e Otto Schellin Nancy Huggins 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Barry D. Potts/ Son 4641 Water Tank Rd. Manchester, MD 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata XX Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Othar (Specify) Cedar Hill Cemetery July 13,1999 Suitland, MD 22. Nama and Addrass of Facility Cedar Hill Funeral Home, Inc. Funeral Service Licenses 4111 Pennsylvania Ave. Suitland, MD 20746 baul 23a. Part 1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each lina. Approximata Intarval Between Onset and Death **Physician** Immediata Cause (Final disease or condition rasulting in death) /Medical Parkinsons + paus Examiner Due to (or as a consequence of). Examiner that the death certificate be axecuted burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue Box 68760. attending physician for use as the burial Physician/Medical Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part It. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. e di signed by to 1 Yes 2 No 3 Probably 45 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen Dulmonary pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No f or Attending Physicien: after death. director, 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 27No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After thi 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After Joompletely filled in by the fun 1 Naturat 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide Medical 29a, Certifier Descripting Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainler as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37573 30. Name and addrass of person who completed cause of death (ttem 23a) (Type, Print) Park Battime Jef Zibell Ave 7770 31. Data filed (Month, Day, Year) 32. Registrar'a Signature 1 2 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 07 09 1999 0:55 am HELEN A. PORTER /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examine Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | Months | Devs | Hours | Min. | (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** 1 M 3 CX Director 577-34-9079 73 10-03-25 Washington, DC Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. Stete 1 X Yes 2 □ No Director None Washington 10e. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? than "natural", or items 23s or the Wedical Examiner must be 118 Madison St., NW 20011 USA filed within 72 hours aftar death v Hygiana. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Meritel Stetus 1 ☐ Yes 2 X No If Yes, Give 1 Never Merried 2 Merried 3altimore, Maryland 21215-0020 1 Yes 2√XNo Specify: Black à 3 Widowed 4 □ Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Salesperson Private 7 is marked other traumatic event, is 18. Mother's Neme (First, Middle, Melden Sumeme) permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any liqury or other traumatic event pags. 17. Fether's Neme (First, Middle, Last) Be James Gaskins Dorothy Lyles 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 912 Delran Pl., Upper Marlboro, Md. 20772 Cliff Porter, Son 20c. Location - City or Town, State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Harmony Memorial Park 7-14-99 Hyattsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
Ralph Williams Funeral Service 76 / 517 11th St., SE., Wash., DC 20003 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner laumon The law requiras that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): P.O. Box 68760. nous Due to (or es e consequence of): 88 USB jo signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, ò 24b. Were eutopsy findings available prior to completion of cause of death? should t 24e. Wes an autopsy performed? Completed has L cartificate ha 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: Be 25. Wes case referred to medicat 28. Plece of Deeth (Check only one) Hospitel: 1 2 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No After this funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred Certification: or Attending 1 X Neturel 5 Pending Investigation 1 Yes 2 No death. octor: 2 Accident 6 Could not be determined 28f. Location (Streef and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral Director letaly filled in b after Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 47867 July 9, 1999 W. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) one Zuniga, 106 Irving St., NW #119, Washington, DC 20010 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State JUL 1 3 1999 Registrar

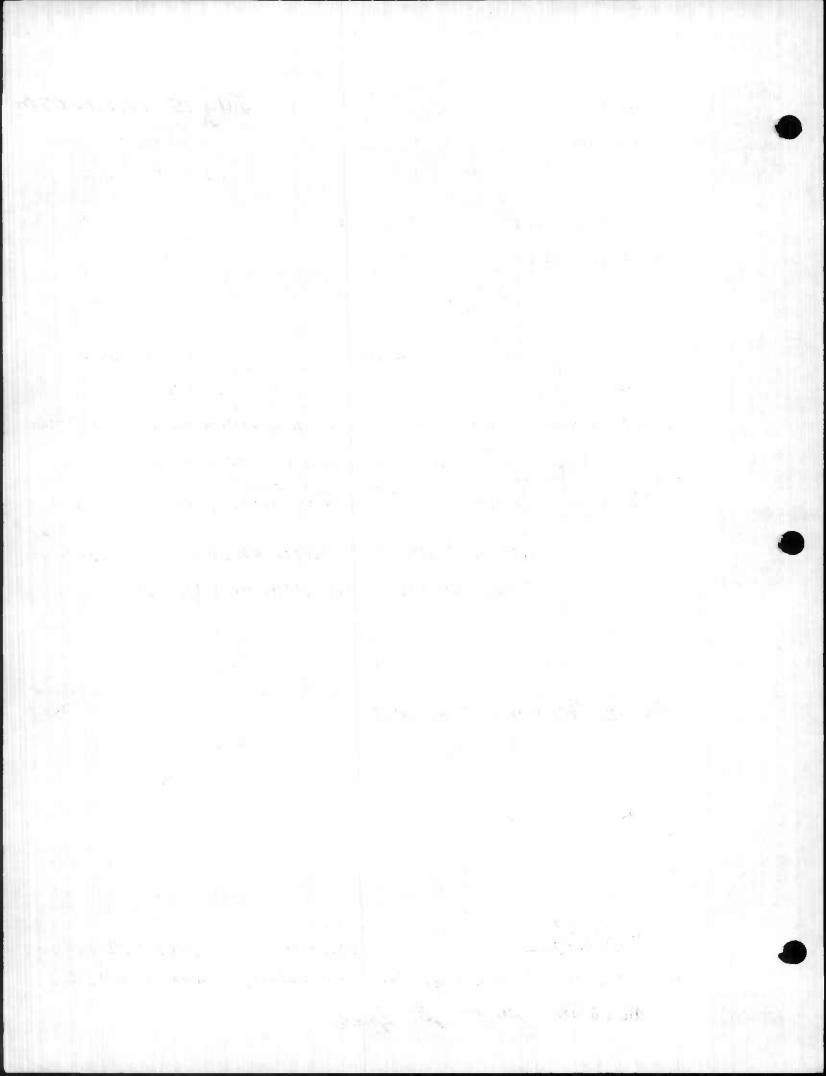


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State of Maryland / Department of Health and Mental Hygiene 99

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					Ce	ertificate of	f Death	Re	eg. No.		
	-	. 1	1. Decedant's Nama (First, Middla, La	ast)				2. Data of Deat		2000	3. Tima of Death
	Physic /Medi		Ferdinand Joh	n Petrait:	is			Jaly	15 1	1999	12:07 A
·	Exami		4a. Facility Nama (If not institution, gir	/a street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
			Doctor's Communi	ty Hospital			Lanham		Princ	e Geo	rge's
	Funeral	Г	5. Social Security Number 6.	Sax 7. Aga (In	yrs. last birthday	/) If Under 1 Year Months Day		8. Data of Birth (Month, Day,			ace (State or Foreign
	Director		330-14-2162 Usual Rasidance of Decedant	18 M 2□F 88	Yrs.	WO'NIIS Day	S Hours Min.	Oct. 5,	1910	IIIi	inois
	how		10a. Stata 10b. County	10	c. City, Town or L	ocation				10	d. Insida City Limits
	Ma Gries	to	Maryland Prince	George's	Coll	ege Park					1 X Yas 2 No
	라 다 라	Director	10e. Street and Number	-		10f. Zip Coda		1	Og. Citizen of	What Count	ny?
	23a		7307 Radcliffe	Drive		207	40		U.S.A		
	Heme Irer In	Funeral	11. Marital Status	12. Was Decedant Evan Armed Forcas?	In U,S. 13.	. Was Decedent of	Hispanic Origin? (Sp. ban, Mexican, Puarto	ecify Yas or No-		e - Amarica	
Maryland 21215-0020	172 hours efter death with the Maryland "natural", or items 23a or 28a-f show potral Examiner must be notitied at	þ	1 Navar Marriad 2 Married 3 Widowed 4 Divorced	1 🏻 Yas 2 🗆 No If Yas, Giva Yaar or Datas: ₩₩		1□Yas 2XN			Specify		
2-0	72 ho	ted	15. Decedant's E	ducation	18a. Dec	edant's Usual Occ	upation	ina	16b. Kind of B	usinass/ind	ustry
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yla		2	Stanley Petra	itis			Adele	Androv	rich		
a	12 should h end Mer 7 is marke traumatic		19a. Informant's Name/Relationship	Type, Print)	19b. Mai	ling Addrass (Stree	et and Number or Ru	ral Routa Number	City or Town,	Stata, Zip	Coda)
Σ.	is 1 end 2 if Health e Item 27 is other trai		Dolores K. Petrai	tis - Wife	7307	Radclif:	fe Drive,	College	Park,	Maryl	and 20740
Baltimore,	Pages 1 end ment of Healt ant: If Item 27 lury or other 1		20a. Method of Disposition		Ob. Place of Disp	position (Nama of ematory or other p			20c. Location -		
Ĕ	Pag nent int: H		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		Gate of	Heaven C	emetery C	7/17/99	Silver	Spri	no. MD
alti	permit. Pages Department of Important: If it any injury or once.		21 Signature of Funaral Sarvice Lice	nsaa /	2	22. Nama and Add	rass of Facility		DIIVCI	DPII	116, 110
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			23a. Part1. Entar tha diseasa, or com	pilcations that causad tha	daath. Do not as	ntar tha moda of d	imore Aven	or raspiratory arra	CSV111		Approximate
	Physician		shock, or heart fawira. List only	ona causa on each lina.							Interval Between Onsat and Death
di.	/Medicai		Immediata Causa (Final	INTRA	CEOFI	2011	HEAMO	OD HAG	6		THE DAVIS
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68760,	cate be executed physician end s the burial-transit	ca	Cause (Disease or Injury that initiated evants	C. Dua	to (or as a conse	unence of).	<u> </u>				
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0.	that the de ed by the deteched	Physician/	•	-	_		givan ni r ant i.		s 2 No	3 Prob	N.
	es that igned to be det	by P	ACUTE K	ENAL F	- ALLU	KE.			20110	0_1100	abiy 4 dikilowii
Division of Vital Records,	requires that the een signed by th hould be deteche	D D						24a. Was a		24b. Wa	ra autopsy findings
00	200	lete						perform	ned?	con	flable prior to nplation of cause leath?
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<u>a</u>								1 □ Ye	7	7	Yes 2□No
₹	Physician: this certific ral director,	Be	25. Was case refarred to medical axaminar?	Hospital:		Fo	ther	th (Check only on			
o	00	. To	1 ☐ Yas 2 No 27. Mannar of Deeth	1 Inpatient 28a. Dete of Injury	2 ER/Outpatie	ALL DOA	4 LI Nursing re	oma 5 Raside)
2		Certification:	1 SNatural 5 ☐ Panding	(Month, Day Ye	ar) 28b. Tima Injury	W		28d. Dascribe ho	w injury occur	rea	
<u>s</u>	Attending in death. Sctor: After by the fune	cat	2 Accident Investigatio 3 Sulcide 6 Could not b				☐ Yes 2 ☐ No	004 111 101	and and Alice		Courte March and
Σ	or Attended efter deat Director:	뒫	4 ☐ Homicide datamined	28a. Place of tnjury - building, atc. (S	At homa, farm, s pecify)	treat, factory, office	9	28f. Location (St. City or Town	n, Stata)	per or Hurai	Houta Number,
_	To the Hospital or Att within 24 hours efter d To the Funeral Direct completely filled in by		non continue a Volume to the								
	To the Hospital within 24 hours To the Funeral completely filled	edicai	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	ysician: To the best of my niner: On the basis of exe	r knowledga, daa minetion and/or li	in occurred at tha nvastigation, in my	tima, data and piace, opinton, daath occur	and dua to the ca red at tha tima, de	tuse(s) and mo ete and place,	and dua to	tha cause(s)
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	8 7 % 7		MA	les .							
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(10) W	7	30. Nama and addrass of person who ASIF S. QADR	completed ceusa of death	(Itam 23a) (Type	Print) R	2910 0, CollE	SE PA	RK	uD:	20740
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	Registi		JUL 1 6 1999	Square	B.	don V	· pi				



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RALPH PR					Cei	tificate	of	Death			Reg. No.	40	001	
Physicia /Medic		Decedent's Name (First, Middle, La RALPH	st) WENDELL		PF	RYOR				2. Date of Dec Month JULY	6, 1999	Year	2220 PM	
Examin	er	4a Facility Name (If not institution, given PENINSULA REGIONAL			TER		ľ	SALIS		cation of Death	4c. County WICOM			
Funeral Director		217-16-9779	Sex 7.	Age (In yrs. 75	last birthday) Yrs.	If Under 1 Months	Year Days	Hours	24 Hrs. Min.	8. Date of Birt (Month, Day September	y, Year) er 29,192		e (State or Foreign yland	
death with the Maryland ims 23a or 28a-f ahow in mait be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomi	LCO	10c. Cit	y, Town or Lo Salist							10d.	Inside City Limits 1 ☑ Yes 2 ☐ No	
23a or 28	ai Director	10e. Street and Number 1007 Phillips A	Ave.			10f. Zip C	ode 180	4		- 4	10g. Citizen of V USA	What Country	7	
of a standard	by Funeral	11. Meritel Stetus 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 New Married 3 New Mexican, Put 1 Never Married 2 New Mexican, Put 1 Never Married 2 New Mexican, Put 1 Never Married 2 New Mexican, Put 1 Never Mexican, Put 1					in? (Spe , Puerto I	city Yes or No- lican, etc.)	14. Rac Bled Specify	e - American ck, White, etc.			
within then	Completed	15. Decedent'a E. (Specify only highest gra	ducation ide completed) College (1-4c	or 5+)	(Give life. I	tent'a Usual kind of work DO NOT use	retired	during most f)	of workir		16b. Kind of Bu			
5 8 3 5 5 E	To Be C	17. Father's Name (First, Middle, Last, Theodore Quintir			11			18. Mother		(First, Middle, Parsons	Maiden Surnam	10)		
Mar nd 2 sh lith and 27 le m r treum		19a. Informant's Name/Relationship (/Wife 1007 Ph								ry, MD 21804		
Saltimore, emit. Pages 1 a Pepartment of Her montant: If item ny injury or othe		20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.		State 20b. Place of Disposition (Name of cemetery, crematory or other place) Wicomico Memorial Park 22. Name and Address of Facility					i	/10/99	20c. Location - Salisb	City or Town		
Demit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licer	Chome	MOIO	51 1	Hollow 501 Sn	ay	Funera Hill	al H	Salish	oury, MD		ociation	
Physician /Medical Examiner		23a. Part1. Enter the disease, or com ahock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that calls one cause on each				of dyin	ng, such as o	cardiac o	r respiratory ar	rest,	Int	pproximate terval Between nset and Death	
certificate be associted certificate be associated and right physician and use as the bunal-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (d	or as a conseq	uence of):						1 1 1 1		
	Physician/M		d							L con state				
that the detaches	by Phys	Part II. Other algnificant conditions of	ontributing to death	Dut not res	uring in the ui	nderrying cau	use giv	en in Parti.		1 🗆 1	_	3 Probat	e cause of death?	
Should a should be	Completed b									24a. Was perfo	an autopsy med?	availe	autopsy findings ble prior to letion of cause ath?	
ate h	0	25. Was case referred to medical						26 Place	of Death	(Check only o	(es 2□No	1/24	es 2□ No	
	ToB	examiner?	Hospital:	itient XX	ER/Outpatien	t 3 DOA	Oth	or.			dence 8 Oth	er (Specify)		
After fune		27. Manner of Death 1 Natural 5 Pending investigation	71610	oluny Day Year)	28b. Time of Injury 2151	280 M	c. Injur Wor	y at k? Yes 2451N			now injury occur hicke col			
UNDSIG	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of	Injury - At h etc. <i>(Specil</i>	(4)	eet, factory,	office		2	City or Tov	Street and Numb on, State) Mod nico, Mod	Per or Rural R R4/2 S	andy Acres	
o the Hospi vithin 24 hou o the Funer ompletely fill	edical	29a. Certifier (Check only one)	yalcian: To the bes niner: On the basis and manner	of examina	wledge, death tion and/or inv	occurred at restigation, in	the tin	ne, date and pinion, deat	d place, a h occurre	and due to the	cause(s) and me	enner as state and due to th	e cause(s)	
To To E	Σ	29b. Signature and title of certifier				29¢.	Licens	e number			29d. Date signe	d (Month, De	y, Year)	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Churk no 111 Penn St

31. Date filed (Month, Day, Year)

JUL 0 8 1999

32. Registrar'a Signature

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E

JULY 7, 1999

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of Maryland / Department of Health and N	fental Hygiene	9 23	38	3	8
Certificate of Death	Reg. No.	W 640 C			
	a Data of Death		2 Tim	-	Dad

1. Decedent's Nama (First, Middla, Last) 5025 E. Pinkett Month **Physician** 2498 /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 M 2 F 84 Yrs. Director Dec. 5, 1914 Maryland 217-05-2460 Usual Residence of Decedent with the Meryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or itama 23a or 28a-f ehow the Wedical Examiner must be notified at 1 Yes 2X No Directo Maryland Wicomico Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9714 Wallertown Road 21837 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian. 11. Marital Status Black, Whita, atc. hours after 1 Yas 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married C 21215-0020 1 ☐ Yes 2 No Specify: P - 3 Widowed 4 □ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry filed within 72 Elamentary/Secondary (0-12) 8th College (1-4or 5+) Hygiene Sewing Factory dress presser is marked other aryland permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other treumatic event bloss. 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Gertrude Mason Waller 395 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 1100 Peach Blossom Ave. - Cambridge, MD 21613 Gene Pinkett/son altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 7/10/99 Salisbury, Maryland Green Acres Mem. Park 22. Name and Address of Facility 213 Jersey Road - Salisbury, Melo Jolley Memorial Chapel plications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, one clause on each light. Approximata Interval Between Onsat and Death Part1. Enter the disaasa, or complica shock, or heart failure. List only one **Physician** Immediate Causa (Final disease or condition resulting In death) /Medical arrhy ardiac **Examiner** Due to (or as a consequence of): Physician/Medical Examiner myocardia ettending physician and for use as the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due fo (or as a consequence of): Box 68760. that initiated events resulting In death) Last Due to (or as a consequence of): 88 signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen page 2 certificate hes 1 ☐ Yes 2 ☐ No 1 Tes or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 24 hours after death.

Funeral Director: After this detely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural
2 Accidant 1 ☐ Yes 2 ☐ No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) within 2

> 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day

29b. Signature and title of certifier

08 1999

Char

State Registrar

Jr MAN IVIA 32. Registrar's Signatura

Sparks

29c. License number D 3 0 8 5 3

29d. Date signed (Month, Day, Year)

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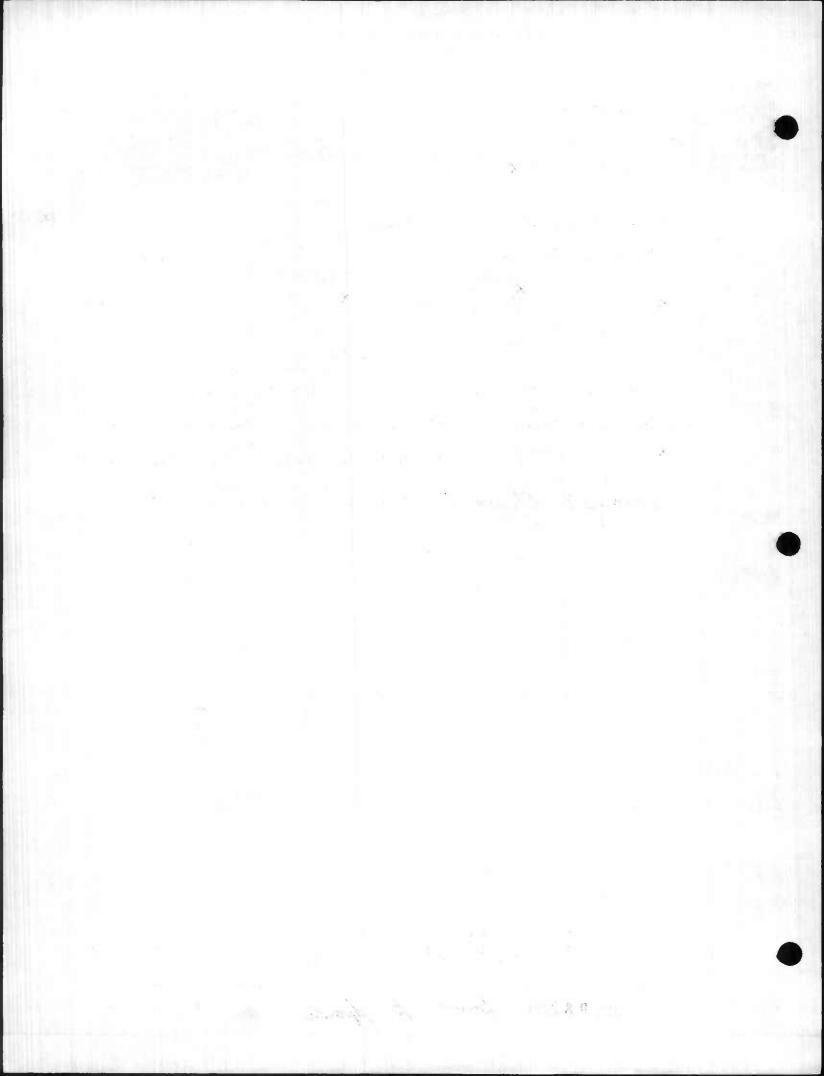
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State of Maryland / Department of Health and Mental Hygiene

23839

Examiner 22516 Wetipquin Road 22516 Wetipquin Road 213-24-0144 \$1 \toperate{2} \	3. Time of Death 4:55 PM Diece (State or Foreign arryland Od. Inside City Limits 1 Yes 2 No
Marguerite Alma Perry Special Security Number 4s. Excitiv Neme (first intellution, pive street early marber) 4s. Exp. Town, country of Deeth Quantico Quanti	olece (Stete or Foreign aryland Od. Inside City Limits
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Social Security Number 213 - 24 - 0144 1 m s/c 7. Age (fit yet, last birthday) 10 c (lay, 1 m) 10 c (lay, 1	aryland Od. Inside City Limits
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10e. Sieve 10e. County 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City, Town or Location 10e. City Code 21856 U.S. A 11. Merital Status 11. Merital Sta	
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	bably 4 ☐ Unknown
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29a. Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner es steed. 29a. Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner es steed. 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, D	leted. the cause(s)
# 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, D	Day, Yeer)
1 DECAMO 026278 7-7-89	9
	/
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David Carell MD 145 E. Carroll St. Solis 4, MD 218	26/
State 31. Dete filed (Month, Day, Year) 1999 32. Registrer's Signeture	-



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Marion Earnest Parsons

State of Maryland / Department of Health and Mental Hygiene 99

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	Certificate of Death Reg. No.									
	Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year 3. Time of Death				
Physician /Medical	MARTON			PARSONS					5:28 P.M.	
Examiner	4a Facility Neme (If not institution, give street and number)					Location of Death				
	7235 Sixty Foot Road Pittsville Wicomico									
Funeral Director	5. Social Security Number 216-18-8530 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs. 1 M Onlths Days Hours					8. Dete of Birth (Month, Day, Year) MAY 10, 1921 9. Birthplece (Stete or Foreign Country) DELAWARE				
	Usual Residence of Decedent									
43	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit									
of of	MARYLAND WICOMICO PITTSVILLE							1 ☐ Yes 2Ã No		
natural, or theme 23a or 28a-f show diest Examiner must be notified at sted by Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?								?	
23.0	7235 SIXTY FOOT R		21850			U.S.A.				
ir, or hams ramper in by Fune	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 12 Yes 2 No lif Yes, Give Year or Deles:			int of Hispanic Origin? (Specify Yes or N ly Cuban, Mexican, Puerto Rican, etc.)		14. Rece - American Indian, Black, White, etc. Specify: WHITE			
ygens. No then "natural", It, the Medical Ex-	15. Decedent's Ed	15. Decedent's Education 16a. Decedent's Usual Occ				1	16b. Kind of Business/Industry			
o o	(Specify only highest grade Elementary/Secondary (0-12)	(Give kind life. DO	(Give kind of work done during most of working life. DO NOT use retired)							
om o	12	College (1-4or 5+)	SELI	SELF - EMPLOYED			FARMER			
2	17. Father's Neme (First, Middle, Last)				18. Mother's Na	ame (First, Middle, Meiden Sumeme)		e)		
arked o	THOMAS ASBURY PARSONS ANNI					E L. WHITE				
trauma	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing A	ddress (Street	and Number or R	or Rural Route Number, City or Town, State, Zip Code)				
rtre rtre	DARLENE COOPER -	DAUGHTER	P.O. F	30X 101	PITTSV	ILLE, MD	21850			
other other	20a. Method of Disposition	20b.	Place of Dispositio	n (Name of	1		Oc. Location -	City or Town	ı, State	
	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State				7/11/00	DIEMMON		100	
important: If any injury or pose.	21. Signature of Funeral Service Licens	7	TTSVILLE	MEMEIE ame and Addre			PITTSV			
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	BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804									
aminer	Immediate Cause (Final disease or condition resulting in death) a. Cint of Shape of Christ Due to (or as a consequence of):									
s the burlat-fransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):									
5 E	resulting in death) Last	d	end to for an accusationing oil.							
e atto	Pert II. Other significant conditions co	en in Pert I.	23b. Did tobacco use contribute to the cause of death?							
should be detached for use leted by Physician/						1 Yes 2 No 3 Probably 40 Unknow				
O D							. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?			
eged FO						1 DYes	2 □ No	DOY	res 2 No	
rector, page Co	25. Was case referred to medical				26. Place of De	eath (Check only one)			
I direc	examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home V Residence 6 Other (Specify)								
Ties C	27. Manner of Death	28a. Dete of Injury 28b. Time of 28c. Injury at				28d. Describe how injury occurred				
o fun	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 No	Subject	Shot	self		
Completely filled in by the funeral director, page Medical Certification: To Be Com	3\\(\sum_\) Suicide 6 \(\sum_\) Could not be determined	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)				281. Location (Street and Number of Flural Route Number City or Town, Stete) 72355, xt, forel Rom				
pletely fill	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to tha cause(s) and manner stated.									
To the Funeral completely filled								9d. Dete signed (Month, Day, Year)		
. H	Theolan M. High O.C.M.E.					July 08, 1999				
54h.	30. Name and address of person who o	ompleted cause of death (ite			treet. B	altimore,	Marv]	and 21	201	
Chate	111	- 7					1			
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign		Peill 5	iteet, E	атсшюте,	магута	31107 517	201	

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State of Manuard / Department of Health and Mental Hygiene

Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 5, JULY 1999 10:45 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Rehabilitation | Rehabilitation Berling I HUnder 24 Hrs. 6. Sak 1 M 200 F 6. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Months Deys Hours 91 **Director** 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show lorces 1 No 2 No Director 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number Funeral Raca - Amarican Indian, Bleck, White, etc. "natural", or items 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Merried 2 Merried 1 ☐ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: 21215-0020 p 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: lack Be Completed 16a. Decedent's Usuef Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than any injury or other traumatic avent, or a least page. Elementary/Secondary (0-12) College (1-4or 5+) altimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Purvell George harlotte Henry 19a. Inf "t's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town) State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Berlin Courin. 20c. Location - City or Town, Stete 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 7-10-99 Berlin 21. Signature of Fuheral Service Licensee Smith Funsal Home Tsahella St, ot enter the mode of dying, suc rence 23a. Pint I Enter the disease, or or plications that caused the deeth. Do not enter short, or heart tellure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be assecuted within 24 hours start death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the bunkl-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. Runios Physician/Medical Due to (or es e consequence of): Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown dial suffice Division of Vital Records. Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1□ Yes 2No 1 Tyes 2 No 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Neturel 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a, Certifier 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 0 DR. FEDERICO ARTHES, M.D., 46 TEAL CIRCLE, BERLIN, MD. JUL 13 32. Registrer's Signeture State 1999 Registrar

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death **Physician** Day Gladys Marie Reed 5, July 1999 2:45pm /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Doctors Community Hospita1 Prince George's Cd Lanham 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Yeer) 5. Social Security Number Birthplace (Stata or Foreign Country) **Funeral** 1 □ M 2 1 F 216-44-3073 95 Director May 3, 1904 Massachusetts Usual Rasidence of Dacedent 10a, Stata 10c. City, Town or Location r is marked other than "natural", or items 23s or 28s-f show traumatic event, the Moderal Examinar maint or notified at 10d. Insida City Limits Directo 1X Yas 2 □ No Maryland Prince George's Lanham 10e. Straat and Number 10f. Zip Code 10g. Citizan of What Country? U.S.A. 7223 Kempton Road 20706 Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 12. Was Dacedant Evar in U.S. 14. Race - Amarican Indian. Armed Forces?

1 Yas 24 No
If Yas, Giva
Yaar or Datas: Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 🖾 No Completed by Specify: 3 XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If frem 27 is marked other than Collaga (1-4or 5+) 12 Secretary U.S. Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Be Louis E. Zerbelle Annie Veronica Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 211-A East Palmer Drive, New Bern. NC Lewis H. Reed - Step-Son other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata Departit. Pages
Department of
Important: If It
any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 07/10/99 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funarai Sarvice Commsaa 22. Nama and Addrass of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiac or respiratory errest, shock, or haert fedure. List only one cause on eech line. Approximate interval Between Onset and Death **Physician** /Medical Immediata Cause (Finel BRAIN HAEMORR AGE disaasa or condition Examiner Due to (or as a consequence of): Examiner FIBRILLATION ATRIAL **burial-transit** Saquantially list conditions, if any, laading to Immadiata causa. Entar Undarfying Causa (Disaase or injury that initiated avants rasulting in death) Last and Dua to (or as a consequance of) Physician/Medical the Dua to (or as a consequance of) as for use Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. been signed by the a 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Wara autopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy performed? page 2 certificate 1 Yes HNO 10 Yes 20 No 25. Was case referred to medical Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) Certification: To 1 Yes 2 No this funeral 27. Mennar of Beeth 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Naturat 5 Panding invastigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straet, factory, offica building, atc. (Specify) filled in by 4 - Homicida 24 hours 12 Cartifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29e. Certifian Medical (Check only one) ZU Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Myill MD D0050951 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) 6510 KENIL WORTH RIVER DALE M.D20737 BURNUE REVA. S. GILL 31. Data filed (Month, Day, Year) ,32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar

Baltimore,

The law requires that the death certificate be executed

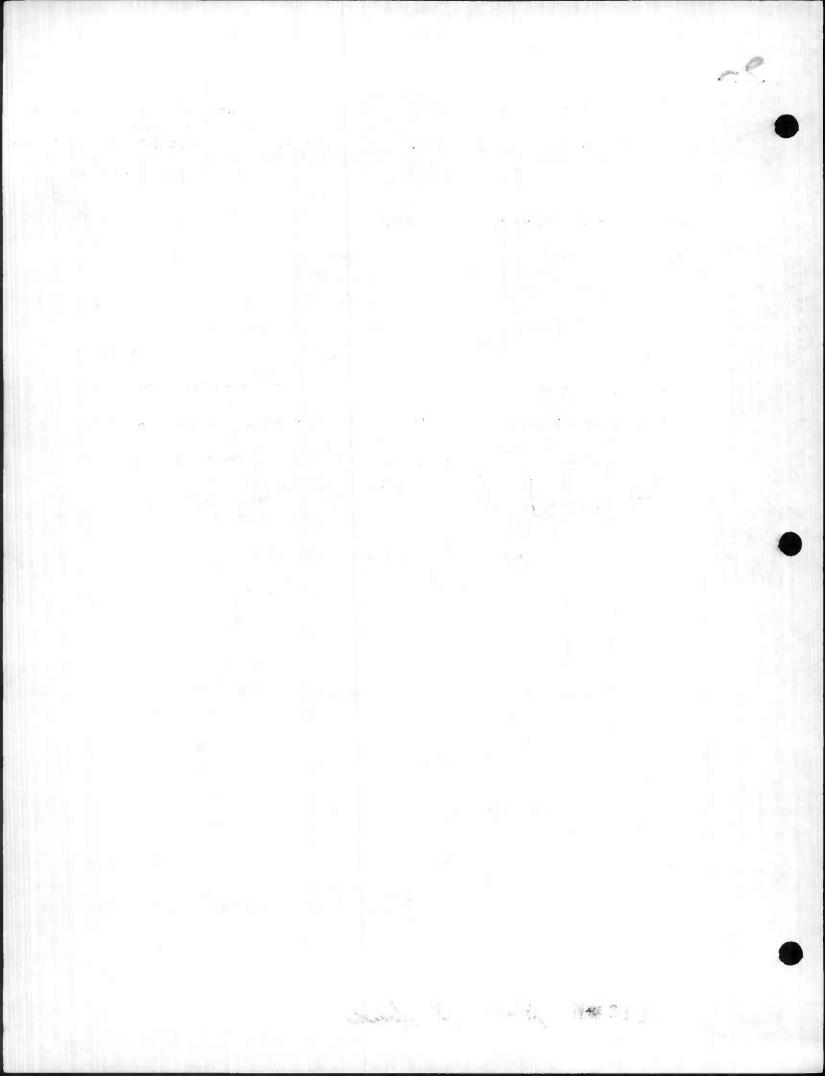
Box 68760,

P.O.

Records,

Division of Vital or Attanding Physician:

Hospital



99-3998-003

Please Type or Print in Black indelibie ink. Assure Ali Copies Are Legible.

99-153 Curtis Ray Rawlings

State of Maryland / Department of Health and Mental Hygiene

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	19	9a. Informant's N	ame/Relations	ship (Typ	oe, Print)		19	b. Mailing	Addrass (Street	and Number o	Aural A	oute Numbe	er, City or Town,	Stata, Z	ip Code)
		Paulin	e Rawl	ings	- Mot	her		55 K	St.	, N	.W. Was	h.,	D.C.	20001		100
20	20	a. Method of Dis		a 🗆 🗆			Ob. Place o	of Disposit	tion (Name	e of her plac	oe)	[Date	20c. Location	- City or T	own, State
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DHMH 16 Rev 6/95

Registrar

THEODORFMIKIG

JUL-1 3 1999

31. Data filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Elizabeth Hintz Rhoads July. 16, 1999 2:05 am /Medical 4a Facility Nama (11 not institution, give street end number) Residence: 10450 Lottsford Road # 133 Collington Episcopal Health Care Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Mitchellville If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 2X F 578-20-7451 98 Director 30, 1900 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 10d. inside City Limits 1 Yes 2 No Director Maryland Prince George's Mitchellville 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Road, #133 20721 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: p 3 X Widowed 4 Divorced White Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Register Nurse Hospital other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oths any Injury or other traumatic event, pines. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Surname) B William G. Hintz Elmira Elizabeth Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John W. Rhoads - Son 16110 Amethyst Lane, Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/22/99 Arlington National Cemetery Arlington, Virginia 22. Name and Addrass of Facility
Gasch's Funeral Home, P.A. 21 Signature of Flu eral Sentice Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 DOW 23a. Part1. Entar the death, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failule. List only one cause on each line. **Physician** cute Myelogenous Leukenia /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or tnjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown þ been significant 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? ate has 1 Yes No 1 Yes 2 No 25. Was case referred to medical examiner? 89 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Naturat 5 Pending Investigation 1 Yes 2 No hours after deeth uneral Director: / 2 Accident 28f, Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hou. 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MAD July 16, 1999 an who completed cause of death (Item 23a) (Type, Print)

State Registrar

William Duboyce, M.D., 79 Kettering Drive, Upper Marlboro, Maryland 31. Date filed (Month, Day, Year) JUL 1 6 1999 22. Registrer's Signature

the Maryland

death

72 hours after

that the death certificate be assecuted

Box 68760

P.O.

Records,

Division of Vital Attending Physician:

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Baltimore, Maryland 21215-0020

1237 3 8 1313

Physician

/Medical

Examiner

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Examiner

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Certification: To

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Cartificate of Death

3. Time of Deeth

6:40AM

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28a-f ahow confined at	Usuel Residence of Decedent 10e. Stete 10b. Count MARYLAND C	HARLES	10c. Cit	y, Town or Lo		AI	TON						10d.
D 80	10e. Street and Number P • O • BOX 327				10f. Zip C		20611			10	g. Citizen of U . S		intry?
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Importar any Injur once.	21. Signature of Funeral Service		,	22	Name end	Addre	ss of Fecilit	У		a la constant	CE,P.		

10d. Inside City Limits 1 ☐ Yas 2 X No

Approximata Intervel Between Onset and Death

9. Birthplace (Stete or Foreign MARYLAND

14. Rece - American Indian. Bleck, White, etc. Specify: WHITE

U.S.POST OFFICE NEWBURG, MD. (RET)

16b. Kind ot Business/Industry

LA PLATA, MARYLAND 20646

20c. Location - City or Town, Stete ISSUE, MARYLAND

22. Name end Address of Fecility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart tailure. List only one cause on each lina. immedieta Cause (Finel diseese or condition resulting in deeth)

SEPTIC

NEUMONIA

Due to (or es e consequence of):

Due to (or es a consequence ot):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaese or injury that initieted events resulting in death) Last

Pert ii. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert i.

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Cerebrovascular Accident

24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? TO YUS BAND 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete ot injury (Month, Dey Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

27. Manner of Death 1 Neturel 2 Accident 3 Sulcide

4 I Homicide

5 Pending investigetion 6 Could not be determined Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yea 2 ☐ No

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, daath occurred at tha time, dete end plece, and due to tha ceusa(s) and menner as stated.

2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at tha time, dete end plece, and due to the causa(s) end menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

29b. Signeture end title of certifier luh

MD

53885

9

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

Venkat S. Ramanan, MD. 6 Post Office Road Suite 101 Waldorf, Maryland 20602

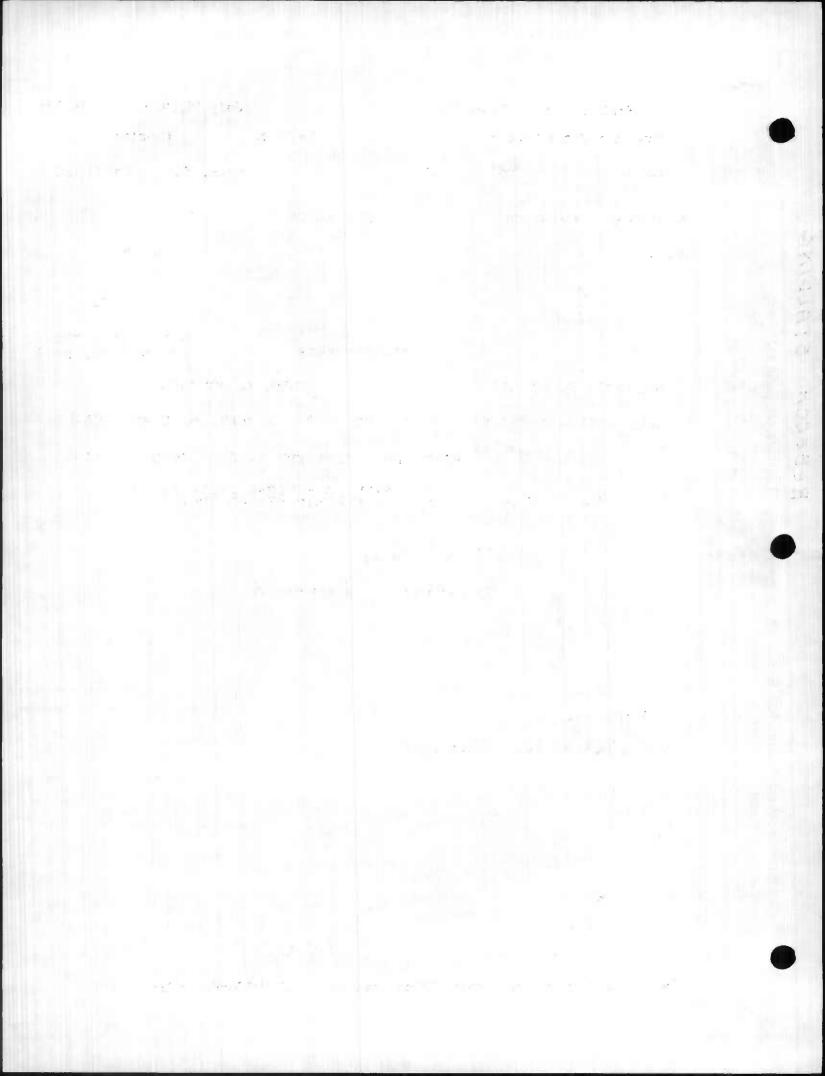
State Registrar 31. Dete filed (Month, Dey, Yaar) JUL 1 9 1999 32. Registrer's Signeture

SPALDING

Division of Vital Records, P.O. Box 68760

or Attending Physician: The law requires that the death certificate be executed

To the Hosp within 24 ho To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 23846 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Patrick Spillane, Sr. 2155 PM 1999 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death 6319 PLACE Cheverly Prince 6 eoper If Under 1 Year If Under 24 Hrs. 8. Defe of Birth Months Deys Hours Min. April 10, 7. Age (In yrs. last birthdey) 1⊠M 2□ F 1936 Connecticut Yrs. 63 10b. County 10c. City, Town or Location 10d. Ineide City Limits 1 Yes 2 No Maryland Prince George's Cheverly 10g. Citizen of What Country? 10f. Zip Code 2819 63rd Place 20785 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2♥ No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) 5+ Teacher High School 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Thomas Spillane Mary Driscoll 19e. Intorment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas P. Spillane, Jr. - Son 9354 South Whitt Drive, Manassas Park, VA 20111 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dete 1 M Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete Lakemont Memorial Gardens 07/13/99 Davidsonville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Fecility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23e. Peri 1. Enter the prieses, or complete lons that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, chock, or heart tailure. List only one cause on each line. Approximate intervei Between Onset and Deeth Hypertensine Cardio VASeulas Disense Due to (or es e consequence ot): Due to (or es a consequence ot): Due to (or es e consequence ot): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end manner as steted. 22 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) P11804

2 should be filed within 72 hours efter death vand Mental Hygiene.
Is marked other than "natural", or flems 23 Baltimore, Maryland 21215-0020 other traumetic avent, mit. Peges 1 end 2 sh partment of Health and Important: If frem 27 is m any injury or other traum pnce. **Physician** /Medical Examiner physician end the burial-transit the death certificate be executed Box 68760. Division of Vital Records, P.O. signed by t certificata hes

Examiner Physician/Medical 85 85 080 ð Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at

Thomas

2819

10e Stete

Directo

Funeral

à

Completed

5. Sociel Security Number

044-26-7686

10e. Street and Number

Usuel Residence of Decedent

Elementery/Secondary (0-12)

20e. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

1 Yes 2□ No

27. Menner of Deeth

1 Neturel

2 Accident

3 Suicide 4 - Homicide

(Check only one)

29a. Certifier

or Attending aftar death. hours a 24 hours within 2 To the F the 0

this

Registrar

Medical

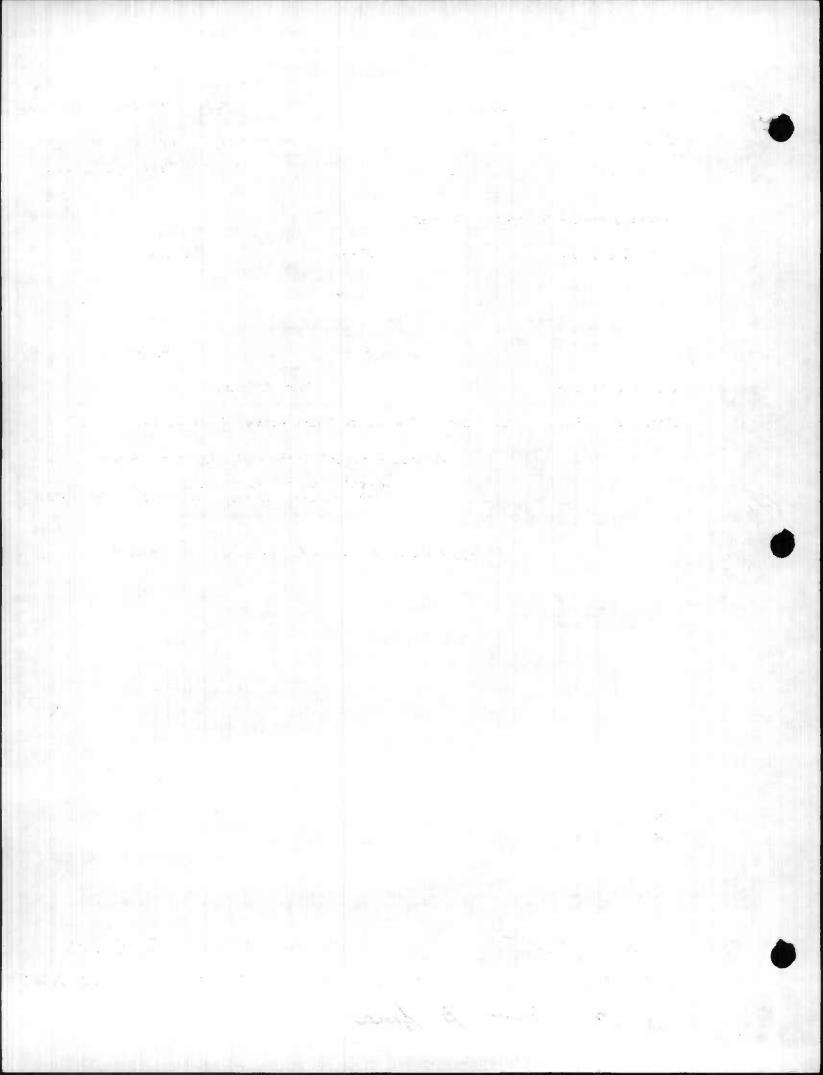
Hospital Drive, Cherry Mary land 20785 32. Registrer's Signeture

3001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

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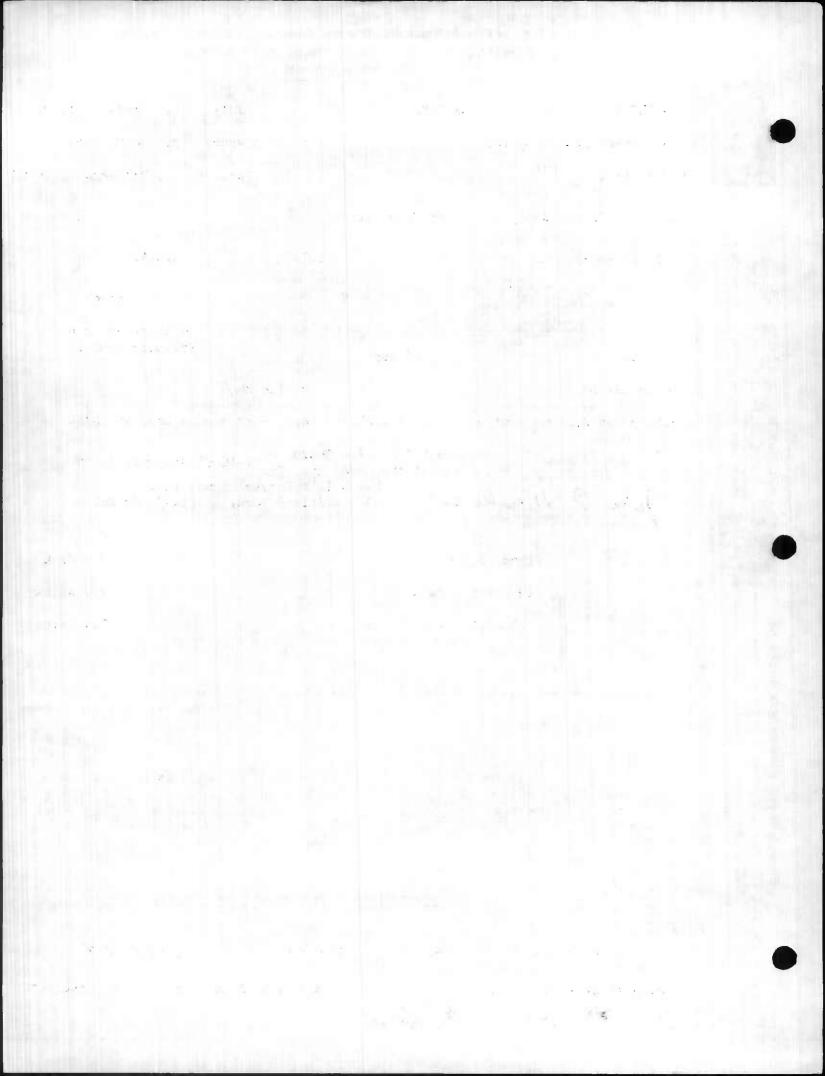
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 99 23847

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	/Medical Examiner			re street and number)			4b. City, Town, or	Location of Deeth	4c. County	of Death		
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	Funeral	5. Social Security			e (In yrs. lest bir	thdey) If Under 1 Ye	ar If Undar 24 Hrs	8. Deta of Birth			placa (State or Foreigntry)	gn
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	the Hospital or At in 24 hours after of the Funeral Direct plataly filled in by ledical Certiff	29a. Certifier (Check only one)	2 Medical Exa	niner: On the basis o and manner st	f examination an	n, death occurred at the d/or investigation, in m	e time, date and place ny opinion, death occ	curred at the time, o	late and place,	and due t	o the cause(s)	
	ST CO	29b. Signature ar	nd title of certifier			29c. Lic	ense number	1	29d. Data signe	d (Maryth,	Day, Year)	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedant's Neme (First, Middla, Last) Month **Physician** 7, 1999 SHARPE 22:20 WILLIAM JULY /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HOPKINS HOSPITAL BALTIMORE JOHNS Baltimore City 7. Age (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplaca (Stata or Foraign **Funeral** 1 M 2 D F 48 1950 Washington, DC Director 220-54-0426 Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow notflied at 1 Ves 2 □ No Directo Maryland Anne Arundel Glen Burnie 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? r than "natural", or flame 23a or the Medical Examiner must be 7877 Crilley Road 21060 U.S.A. death Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 12. Wes Decedent Ever In U.S. Armed Forcas? 14 Race - American Indian 11. Maritai Status Black, Whita, atc. d 2 should be filed within 72 hours after th and Mental Hygiene.
7 Is marked other than "natural", or its traumatic avent, the Medical Examinal 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas: 1 Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16h Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Electrician Private Industry 18. Mothar's Name (First, Middla, Malden Surname) 17. Father'e Nama (First, Middle, Last) John Patrick Sharpe Margaret Miller 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Comit. Pages 1 end 2 sh Continent of Health and Important: If item 27 is m any injury or other traum page. John Patrick Sharpe, Jr.: Brother 6908 Freeport Street, Hyattsville, MD 20784 20b. Plece of Disposition (Neme of camatary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 07/10/99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 22. Name and Address of Fecility
Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Linns em 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part. Enter the dis asa, or complicet in that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart subre. List only one cause on each line. Approximata Intarval Betwaen Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 5 YEARS LIVER FAILURE Examiner Dua to (or as a consequence of): Examiner physician another the burial-transit death certificate be executed Sequentially list conditions, if eny, laading to Immadiata causa. Enter Underlying Cause (Disaase or Injury thet Initiated evants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 88 9SI ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause page 2 s has 28 No cartificata 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) L_o 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA funeral 27. Mannar of Death 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? Aftar 1 Natural 5 Panding 1 Yes 2 No Invastigation 2 Accidant 6 Could not be datarminad 3 ☐ Suicida Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) à 4 Homlcida

Division of Vital Records. after death. Director: Aft filled in 24 hours To the Hosp within 24 hos To the Fune completely fi

faces, MD RE5-000 Maur 30. Nama end address of person who complated causa of daath (Item 23a) (Type, Print)

ZAA5,600 N. WOLFE STREET, TOWER 110, BALTIMORE, MARKAND 71297

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

JULY

State Registrar

edicai

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Data filed (Month, Day, Year)

32. Registrar's Signatura

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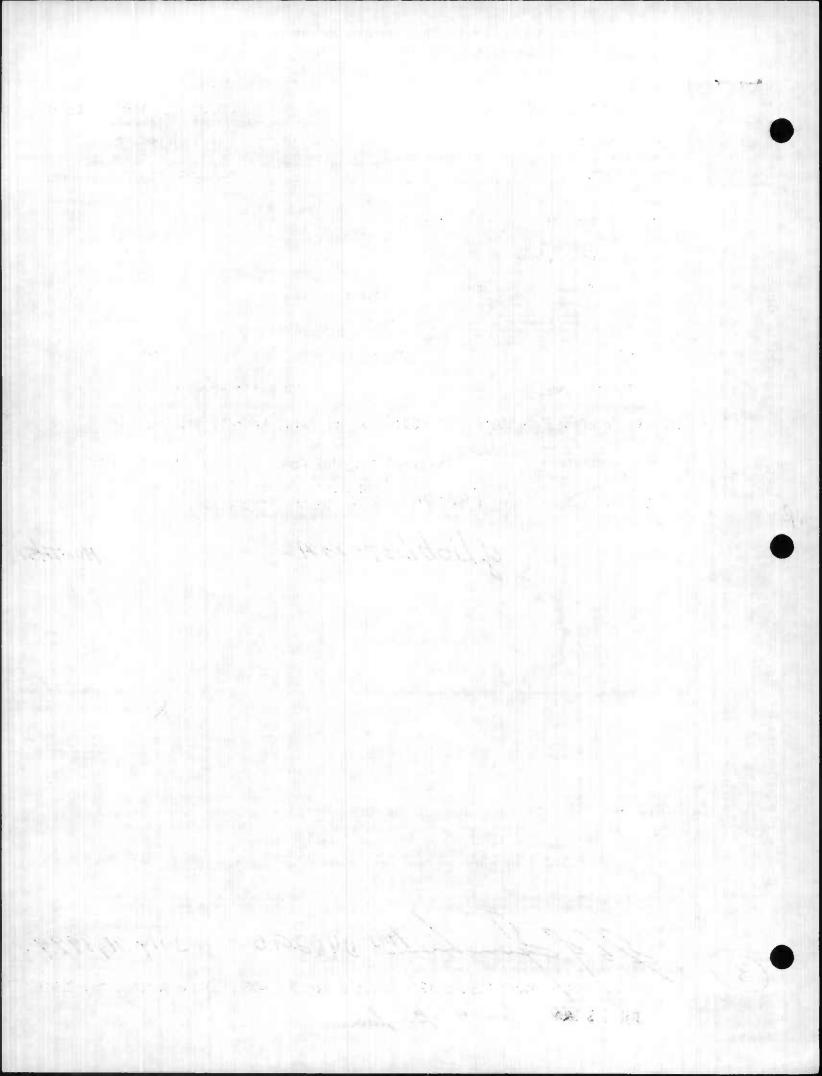
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State of Maryland / Department of Health and Mental Hygiene 99 2381,9

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Physician/Medical Examiner	Immadiate Cau diseasa or con- rasulting in dea Sequentially lis if any, leading t cause. Enter U cause (Diseas that initiated av rasulting in dea	dition tt conditions, to immadiata indarlying a or Injury ants	a. Pan c	Dua to (or as	s a consequence	uance of): ence of):	einom		ne, 65 respiratory arre	Bowie 12 N.	W. Cr	cain Approximat Interval Bet Onset and I	ths
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completely filled in Medical Cert	29a. Certifier (Check only one)	1 ☐ Certifying Pt 2 ☐ Medical Exam	nysician: To the best miner: On the basis o and manner st	f examination	dge, death and/or inve	occurred at the estigation, in n	e time, date and ny opinion, death	l place, an h occurred	d due to the ca at the time, da	ause(s) and m ate and place,	anner as sta and due to	ated. the cause(:	5)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** SELDEN EUGENE 7-25 pm 07 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Cheverly Gladys Spellman Nursing Home Prince George's If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 8. Sex 1 M 2 ☐ F 5. Sociei Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Yrs. 155-14-1438 78 February 28,1921 Director Virginia Usual Residence of Decedent with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland | Prince George's Capitol Heights 10e Street and Number 10g. Citizen of Whet Country? 6322 Martin Luther King Hwy. 20743 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or item only injury or other traumatic event, the Medical Examinat DAGE. 1 X Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorcad Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Accountant Supervisor Government 1+17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Clement A. Selden Gladden Henry 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20743 Vesta C. Selden/Wife 6322 Martin Luther King Hwy., Capitol Heights, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 07/16 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 □ Gremetion 3 □ Removel from Stete
4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 1999 Brentwood, Maryland 22. Name end Address of Fecility
J.B. JENKINS FUNERAL HOME 21. Sign ture of Funerel Servica Licenses 7474 Landover Road, Landover, Maryland 20785 23a. Pert i. Enter the disease, or comprehensive that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only the cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in deeth) Myocardial Influction

Due to (or es e consequence of): Examiner Examiner attending physician end for use as the buriel-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Respiratory failure Physician/Medical Obstructive Pulmonary Direcie Preumonia Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes rullitus Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed Leyperternion Dementia Algheimis 1 Ves 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 9 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dete of tnjury (Month, Dey Year) 28c. fnjury at Work? 28d. Describe how injury occurred 28b. Time of Certification: of or Attending P s efter death. f Director: After 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 D Homicide To the Hospital o within 24 hours of To the Funeral Di t 🟏 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nancy Kalpana (imoty 20052848 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) NANCY K. TIMOTHY

RDL

37. Registrer's Signeture

HYATTES VILLE MD

ANNAPOLIS

31. Dete filed (Month, Day, Yeer) **JUL 1 5** 1999

Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

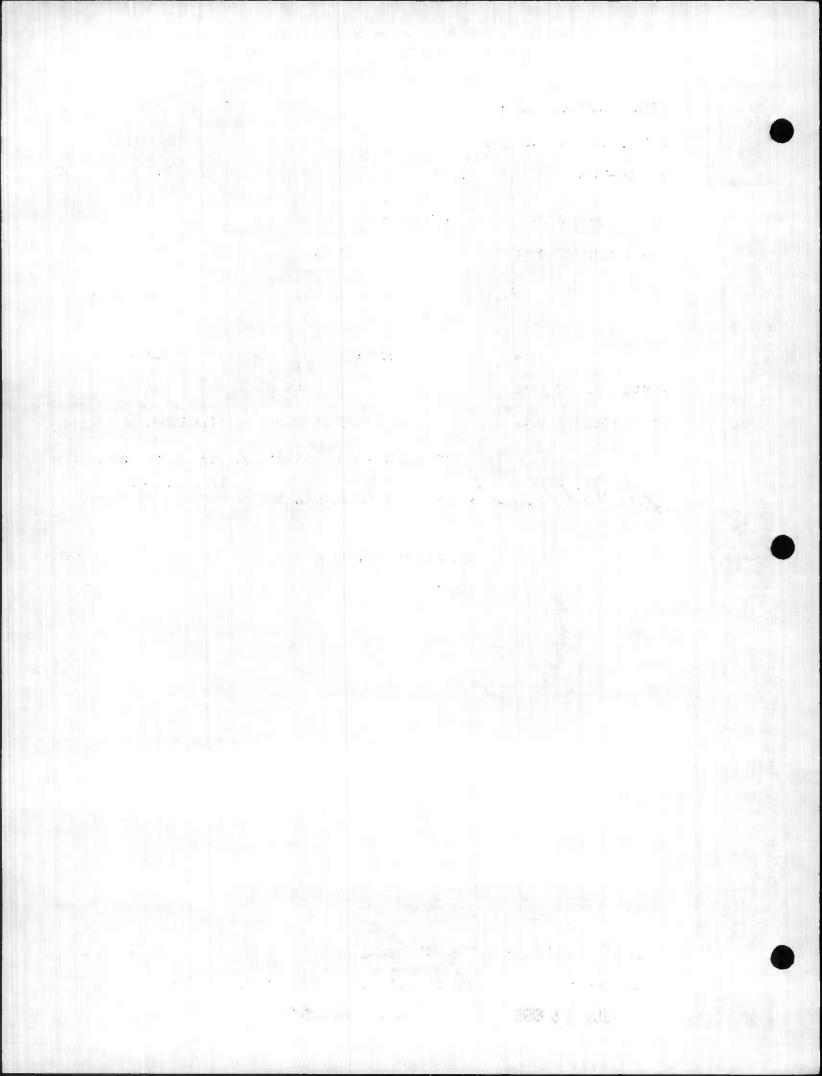
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State Registrar

31. Dete filed (Month, Dey, Year)

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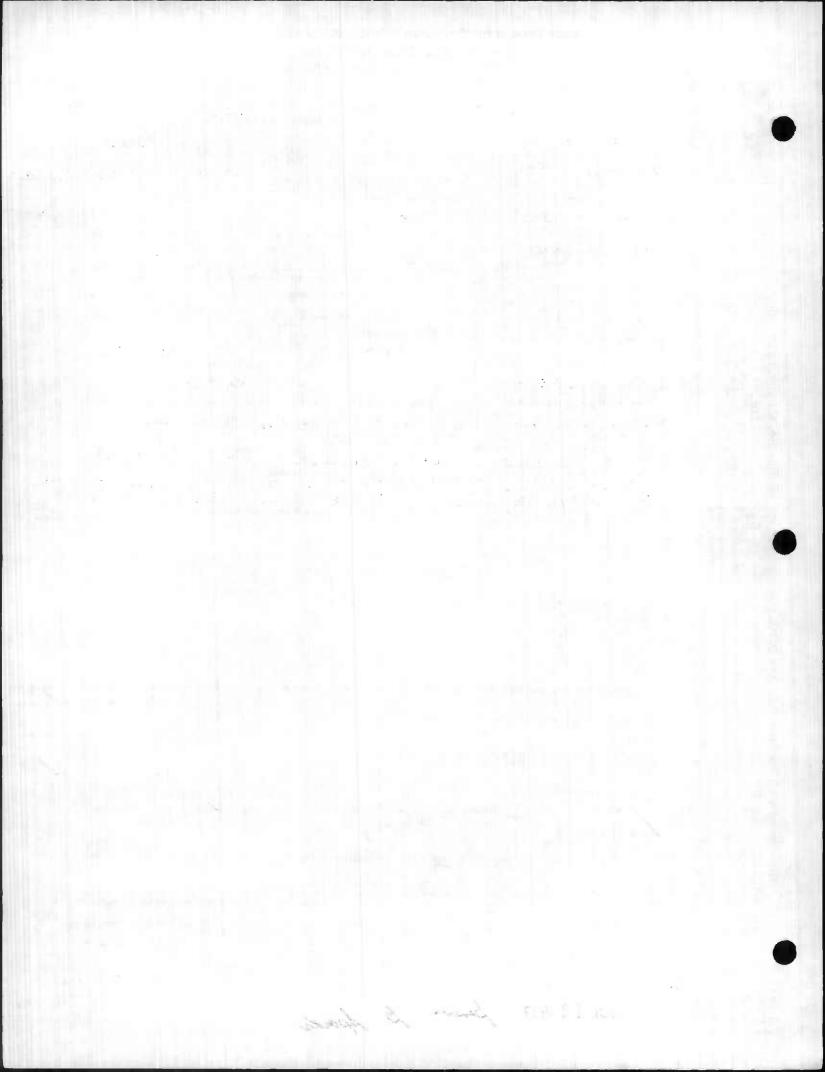


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State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** July 9, 1999
4b. City, Town, or Location of Death 4c. Co 8:30 PM LONNIE GRANT SUITER /Medical 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 14126 BAckbone Road Eden Somerset If Under 1 Year 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Sex **Funeral** Months Deys Hours 1X M 2 □ F 236-58-9659 August 21,1940 Director West Virginia Usual Residence of Deceden the Maryland 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location show r 28a-f show 1 ☐ Yes 2X No Maryland Somerset Eden Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? W CT then "natural", or items 23s or the Medical Examiner must be 14126 Backbone Rd. 21822 USA death . Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indien, 11. Meritei Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours after neat of Health and Mental Hydiene.
Art: If them 27 is marked other than "natural", or ite inty or other traumfile event, the Medical Examinary or other traumfile event, the Medical Examinary. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry ith and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementery/Secondery (0-12) College (1-4or 5+) Carpenter Construction 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Ulysses Grant Suiter Albany Lee ARnett 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Trudy S. Suiter/Wife 14126 BAckbone Rd., Eden, MD 21822 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If any Injury or page. 4 □ Donetion 5 ☑ Other (Specify) Fotombrent 7/14/99 Hebron, MD Springhill Memory Gardens 21. Signe of Funerel Service Licensee 22. Name end Address of Fecility Holloway Funeral Home Professional Association M01051 23e. Pert1. Enter the disease, or complications the used the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart feilure. List only one ceuse on each line. 501 Snow Hill Rd., Salisbury, MD 21804 pproximate tervel Between nset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) conce year Examiner Due to (or es e consequence of): Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): 88 use. signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 □ Probably 4 ☑ Unknown 1 Yes 2 No by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en autopsy performed? Completed s certificate has t director, page 2 s 1 Yes 2 No 1 Yas 2 No Attending Physician: 25. Wes cese referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes /2 No To this funeral 28a. Dete of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Injury 1 (Neture) 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after deatl Director: 8 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide n 24 hours after re Funeral Dire-pletely filled in b ò Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner as stated. edical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certified 29c. License number 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Salisbury Dilliam obins 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JUL 12 1999 Registrar

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

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	Examine		ta Facility Name (If	not institution, gi	ve street end number)				4b. City, Town,	or Location of E	eath 4c	. County	of Death	
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ē,	of Health I fram 27 r other tr	1	20a. Method of Dispo				Piece of D	isposition (Neme (of	Dete	-			wn, State
Baitimore	permit. Pages Department of important: If fu any Injury or o		1 Suriel 2 □ 4 □ Donation 5		Removei trom State			Cemet			7/16/9	9 Wa	ango,	MD	
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60,	ndicate be assected ng physician and as the burial-transit Medical Examiner		Sequentially list conditions any, leeding to immorate cause. Enter Underformasse. Cause (Disease or in	ditions, nediete ying	c	Due to (or as e co	rsequenca	984:						
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ord	been should											Was an auto performed?	psy	av co	era autopsy tindings allable prior to mpletion of cause death?
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	E E E		7. Menner of Death 1 Natural 2 Accident	5 Pending	28a. Dete of Inju (Month, De	iry	28b. Tin	ne of		Injury at Work? 1 Yes 2 No		ibe how Inju			,,
ivision	or Attending frer death. Virector: After in by the fune intification		3 Suicide 4 Homicide	6 Could not be determined		jury - At h c. (Speci	iome, ferm	, street, fed	tory, of	fice	28f. Locati City of	on (Street a	nd Numbe	er or Rura	Il Route Number,

804 IVA

WILLIAM ROBINS, M.D. ,1104 HEALTHWAY DR., SALISBURY, MD. 21804

State Registrar 29e. Certifier (Check only one)

29b. Signeture and title of certifier

1999

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner steted.

29c. License number

D-29349

29d. Dete signed (Month, Dey, Year)

Markey and the second s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend # 4a Per Phys. PGC 7-16-99 cr 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** James Luther Thompson, Sr. Tuly 1999 0745 AM 12 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 901901 Am RERST Road 303 Hyattsville If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, 6. Sex 1 2 M 2 □ F Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 249-38-9239 Yrs. S.C. 6/25/18 **Director** Usual Residence of Decedent with the Meryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or flams 23s or 28s-f show any Injury or other traumatic event, the Mexical Examined must be notified at page. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Hyattsville MD Prince Georges 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code #303 20783 United States 1901 Amherst Rd. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 XWidowed 4 ☐ Divorced Black. Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12TH Maintenance Worker Private 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) 2 Luther Thompson Ola M. Jones 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1901 Amherst Rd. #303, Hyattsville, MD 20782 Son James Thompson, Jr. 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 □ Donetion / Other (Specify) Riverdale Park Crematory 7/17/99 Riverdale, MD 21. Signature of une al ervice Licensee 22 Neme end Address of Fecility Dudley Funeral Home 3200 Rhode Island Ave., Mt. Rainier, MD 20712 Dudley Edward 231. Pert1. Inter the disease, or complications that caused the deeth. Defot enter the mode of dying, such as cardiec or respiretory errest, shock, or haart failura. List only ona causa on each line. Approximata Interval Between Onsat end Deeth **Physician** Metastatic Carcinoma of /Medical Immediata Cause (Final disease or condition resulting in deeth) Examiner Examiner ettending physician and for use es the buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 98 signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown p 24b. Were autopsy findings available prior to completion of cause of death? been s 24e. Wes en eutopsy performed? Completed certificate hes b T□Yes SKNo 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 X Hesidance 8 ☐ Other (Specify) injury at 28d. Describe how Injury occurred 1 X Yes 2 No Hospital: 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Deta of Injury (Month, Dey Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? Certification: Aftert 1 Neturel 2 ☐ Accident 5 Pending investigation 1 Yes 2 No To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Af completely filled in by the fu r death. 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 31. Dete filed (Month, Dey, Yeer)

JUL 1 5 1999

Sylvester Do,

(Check only one)

29b. Signature and title of certifie

Hospital 3001 32 Registrer's Signeture

30. Name end address of forson who complated cause of deeth (Item 23a) (Type, Print)

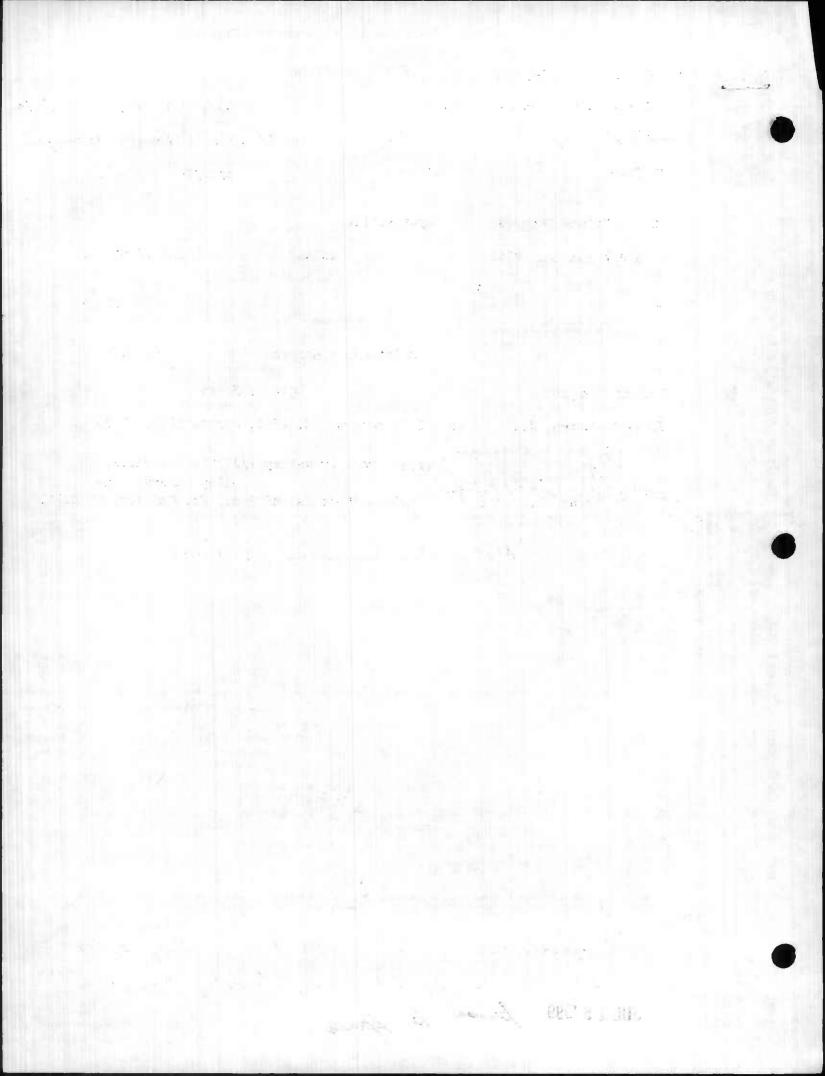
Drive, Cheverly, Manyland

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P11804

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					Cei	tificate of	Death		Reg. No.	9 2	3856
Physic	an	Decedent's Name (First, Middle						2. Dete of De Month	ath Day	Year	3. Tima of Death
/Medi	cai	ROSA LEE TAYLO 4e. Facility Neme (If not institution,		n front			4h Cihi Taur	JULY 1			4:00am
Exami	ner	500 N. HARRY						or Location of Death			
Funeral					s. last birthdey)	If Under 1 Year		MARLBORO Hrs. 8. Date of Bird	PRIN		CORGES
Director		578-42-2451	1□M 2⊠F		74 Yrs.	Months Days	Hours A	Hrs. 8. Date of Bird (Month, De SEPT 1	8,1924	SOUT	place (State or Foreign htry) TH CAROLINA
n ž ==		Usuai Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
3a or 28a-f show	to	MD PRINCI	E GEORGES		PPER MA						1 Ves 2 No
not	Director	10e. Street end Number	2 GLONGED	0	LIEK FIA	10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
23a o	ai D	500 N. HARRY	TRUMAN DR	IVE					UNITE	D STA	TES
CHELLON	Funerai	11. Marital Status	12. Wes Dece Armed Fo	dent Ever in	U,S. 13. V	Ves Decedent of	Hispenic Origin	(Specify Yes or No- uerto Ricen, etc.)	14. Rad	e - Americ	en Indian,
STATE OF	by Fu	1 Never Married AMMarrie 3 Widowed 4 Divorced	ed 1 ☐ Yes If Yes, Giv	2 X No		☐ Yes 2X No		derio Fricari, etc.,		ck, White, y: BLAC	
7 10		15. Decedent	Yeer or Di	ites:	16a Deced	ent's Usuai Occu	nation		16b. Kind of B		
Medical Ex	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	400 50	(Give	kind of work done OO NOT use retire	during most of	working	100. Killa Ol B	usiness/in	dostry
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event,	Be (17. Father's Name (First, Middle, L	ast)				18. Mother's	Neme (First, Middle,	Malden Suman	ne)	
marked matic e	2	JAMES McLEOD						NAH DIGGS			
9 2		19a. Informant's Name/Relationsh						Rural Route Number			
Item 27 other tra		REV. BERNARD M.	TAYLOR	SON 20b.	1622 Place of Dispos	GOLF CO	URSE DR	MITCHE	LLVILLE 20c. Location	MD 2	0721
= 5		1 ☐ Burial 2 ☐ Cremation		State	cemetery, crem	atory or other pla			200. Location	City of To	WII, State
any injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signeture of Funeral Service L				TON NATI Name and Addr		7-16-99	SUITL	AND, M	D
eny ir		100, 1	Q r			ALEXANDE	R S. PO	PE FUNERA			
		23a. Pent1. Enter the disease, or o shock, or heert failure. List of	complications that co	oused the dea	th. Do not ente	617 PENN or the mode of dv	. AVE S	E. WASHI	NGTON D	C_200	20 Approximate
physician and the buriel-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. BRAI	Due to (Due to (METAS	RCINOMA (or as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequence of as a consequence of a consequence	uence of):		· .			
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achec	by Physician/M	Pert II. Other significant condition	s contributing to de	ath but not re	sulting in the un	derlying ceuse gi	ven in Part I.	23b. Dld t		ntribute to	the cause of death?
plnodi	Completed							24a. Was a perfor		ava	ore autopsy findings allable prior to appletion of ceuse death?
irector, page 2 s	E OC							1□ Y	es 200 No	10	Yes 27 No
director,	Be	25. Wes cese referred to medicet examiner?						Death (Check only or	ne)		
ral dire	2	1 ☐ Yes 2 ☐ No			ER/Outpatient	3LI DOA	her: 4 Nursin	Home 52 Resid	ence 6 Oth	er (Specify)
fune	tlon:	27. Many er of Death Netural 5 ☐ Pending Coldent investigs		f Injury n, Day Year)	28b. Time of injury	28c. Inju Wo	ryat rk? !Yes 2 □ No	28d. Øescribe h	ow injury occur	red	
completely filled in by the	Certification:	3 Suicide 6 Could no determin	t be 28e. Place	of Injury - At h g, etc. <i>(Speci</i>	ome, ferm, stre	et, factory, office		28f. Location (S City or Tow		er or Rura	l Route Number,
letely fill	edical	29a. Certifier (Check only one)	Physician: To the baseminsr: On the base and menn	sis of examina	owledge, death ation and/or inve	occurred at the the stigation, in my o	me, date and pla opinion, death o	ace, and due to the occurred at the time, o	ause(s) and ma lete and place,	nner as st	ated. the ceuse(s)
To the Funeral I		29b. Signature and title of dertifier	1	N		29c. Licens	se number	2	29d. Date signe	d (Month, I	Day, Year)
		· (())//-	//)		DAK	5147	3	7/13	199	7
1		30. Name and eddress of person w		1 1		rint)		101	1101		
		Kay She Hran 31. Date filed (Month, Day, Year)	-		murina	59 /	1.5	washing to	7 0.4		
Stat Registra	•	un 1 4 19	99 %	gistrar's Sign	L	/					

DHMH 16 Rsv 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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ı	Physiciar /Medica		1. Decedent's Name			ARDEN								2. Dete of De Month JULY	Dev	9 Yaar		MOON
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	Funeral Director		5. Social Security N 216-22-5 Usuel Residence of	833	6. Sa	ĎM 2□F	7. Aga (In yrs.	last birthday Yrs.	Months	Deys	Hours	Min.	8. Date of Bir (Month, Da MAY 16	th y, Year) 1927	Co	npleca (S untry)	State or Foreign
	land	-	10a. Stete	10b. Coun	ty		1	Oc. Cit	y, Town or L	ocation							10d. Ins	Ide City Limits
	Sa-f sh correct	Director	MD		RETT				OAKLA						40.00			Yes 2□ No
	with the	5	10e. Street end Nur		CELD	ran m				10f. Zip					10g. Citizen	of Whet Co	untry?	
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020	0 0 5	by runeral	1 Nevar Marri			Armed F	orcas?	WW :		If Yes, special 1 ☐ Yas		Specify:	, Puerto	ecify Yas or No Rican, etc.)		Black, White		
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Maryland 21215-0020	H lath d oth even	0 00	17. Fethar's Nema	(First, Middle O		TEA	GARD	EN				18. Mothe		a (First, Middle		name) RGAN		
Mar			19e. Informent's No				TDD							ral Routa Numb			ip Code	
	other tr		ELIZABET 20a. Method of Disp		JAKD	EN - W	IFE	20h F	P. C	osition (Na		-	OAK	LAND, M	D 2155		Town St	ata
Baltimore,	W W		1 Buriel 2	Cremation			Stata	C	KLAND	matory or o	ther plac	ca)		7/6/99	OAKLA			
Balt	permit. Page Department of Important: If I any Injury or once.		21. Signeture 1 Fu	inerai Seglo	Lipips	in I	MO	016		2. Name er				P.O. - OAKL	BOX 2		50	
			23a. Part1. Entar ti shock, or hea	ha diseasa, rt failure. Li	or comp st only o	lications thet	caused th										Appro	oximata ral Between t and Death
	Physician / /Medical		Immediata Causa ((Final					empita c	TEMA	CEVI	ים רוי				1	37	EADC
	Examiner		disaasa or condition rasulting in daath)	n		a	Du		EMPHYS		SEVE	KE					1	EARS
	D == 2							,		,						}		
,0	death certificate be axecuted a attending physician and of or use as the buriel-transit	edical Examine	Sequentially list co if any, leading to im- cause. Enter Under Ceuse (Disaese or	nditions, mediate orlying	ſ	D	Du	e to (o	r as a conse	equance of):								
68760,			that initieted events resulting in deeth) i	5	1	c	Du	e to (o	r es e conse	quence of):								
Box	attending pl	ala				d												
P.0.	the soche	Ä	Pert li. Other signif	icant condi	tions co	ntributing to d	death but i	not res	ulting in the	underlying o	ausa giv	an in Pert I		37	tobacco use Yes 2□ N			ause of death
ecords,	been sign should be	ופופת הא													en eutopsy ormed?		availabia	on of cause
Œ	The law ate has b	5												10	Yas 210N			2 No
Vital	artifical actor. p	U	25. Was case refer	red to medic	al							26. Piece	of Dea	th (Check only	one)	1		
of V	dir dir		exeminer?	No		Hospitel: 1 🗆	Inpatiant	2 🗆	ER/Outpatie			4LI NU	rsing H	ome 5 🛛 Ras	Idence 6 🗆	Other (Spe	cify)	
	Attending Ph ir death. ector: After th by the funeral		27. Mannar of Deat 1 X Neturel 2 ☐ Accident	5 Pend inves	tigetion	28e. Dete (Mor	of Injury oth, Day Y	'ear)	28b. Time injury	of S	28c. Injur Wor 1 🗆	yet k? Yes 2□	No	28d. Dascribe	how injury or	ecurred		
Division	- 2 - c	Celtilic	3 Suicide 4 Homicide	6 Couldete	d not be mined	28e. Piec build	e of Injury ling, etc. (- At he	ome, farm, s	treet, fector	y, office			28f. Location (City or To	(Street and Ni wn, State)	umber or Ri	ural Rout	e Number,
	Hospi 24 hou Funer Hely fill		29a. Certifier (Check only one)	Certify 2 Medica	ring Phy al Exam	iner: On the b	e best of r	camina	wledge, dea tion and/or i	th occurred nvestigation	at the tire, in my o	me, date an opinion, dea	d place, th occur	and due to the red at the time,	cause(s) and date and pla	d manner as ce, and due	stated.	ause(s)
	within 7 to the comple		29b. Signature and	title of certif	ion					29	c. Licens	e number			29d. Date si	gned (Mont	h, Day, 1	(ear)
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31. Data filed (Month, Day, Year)

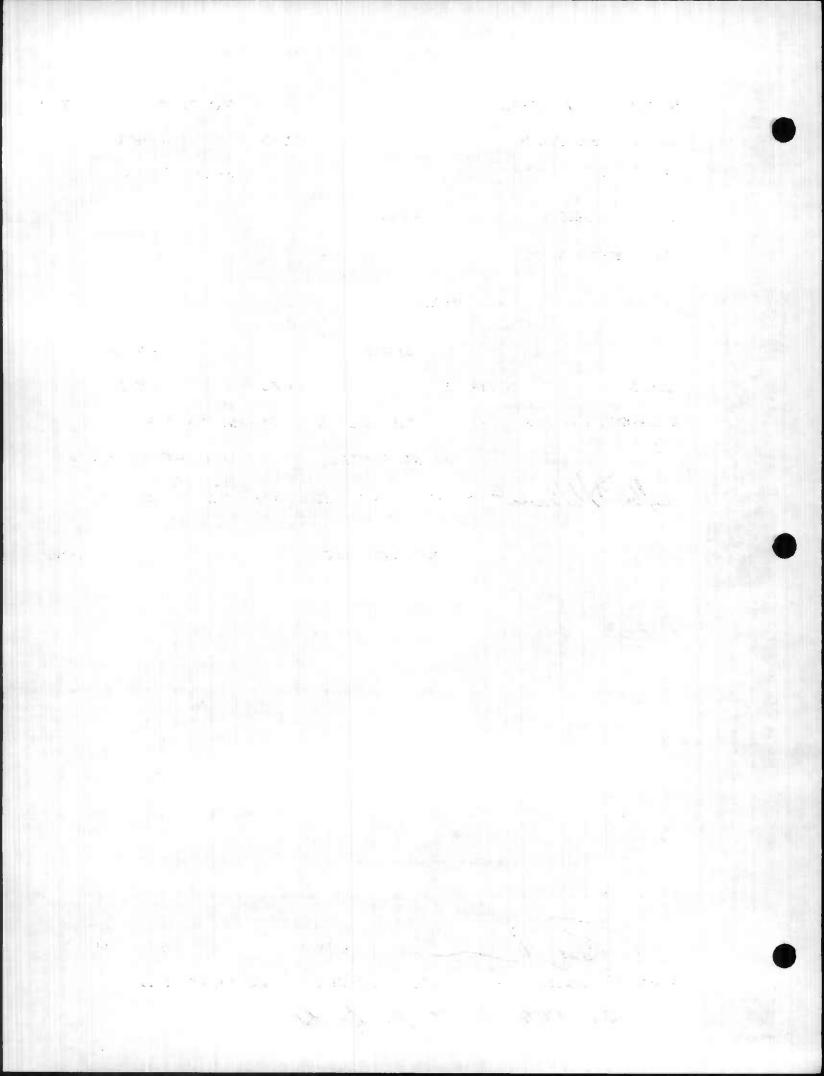
ROBERT A. GORALSKI, M.D.

30. Name and address of personal to completed cause of death (Item 23e) (Type, Print)

OAKLAND, MD 21550

State JUL - 7 1999 Registrar

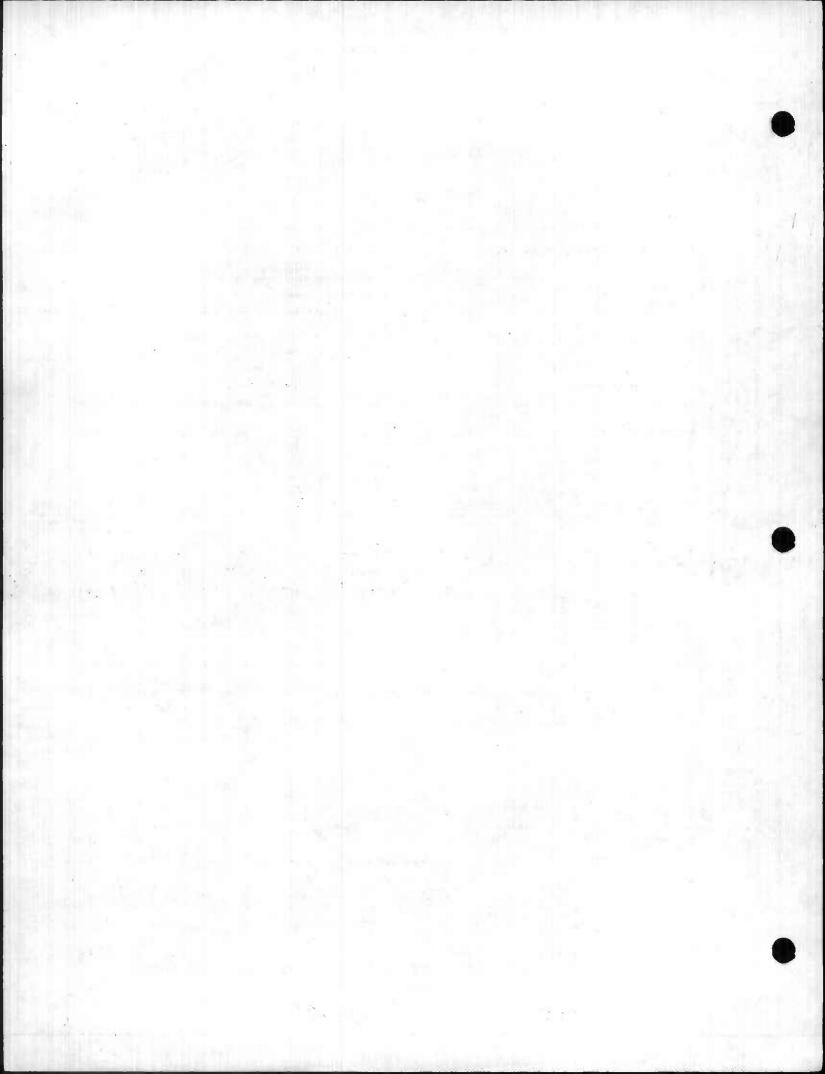
311 N. FOURTH ST.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Name (F	iret Middia	[pet]		Cel	rtificate	OI .	Deam	2. Data of De	Reg. No.		3. Time of Death
Physician /Medical	Harry D			num					Month July	Day	Year	1539
Examiner	4a Facility Nama (If no	t institution,	giva street and nu	umber)			1	4b. City, Town, or L.	ocation of Death	4c. Count		
	5. Social Security Numb		6. Sex	7 Ana (In v	rs. last birthday)	If Under 1 Y	Year	Cumber 1a		Alleg		polace (State or Engine
Funeral Director	232-26-029	93	1⊠M 2□F	78	Yrs.	Months D	Days	Hours Min.	8. Data of Birl Month Da Feb 18	1921		nplace (State or Foreign untry) zmiller, Md
*	Usual Rasidance of Dec 10a. Stata 10	b. County		10c	City, Town or Lo	ocation	_					10d. Inside City Limits
H eho		Allega	iny		awlings							1 ☐ Yes 2 ☑ No
al, or tems 23s or 28s-f show Examiner must be notified at by Funeral Director	10a. Street and Number		Highway	7		10f. Zip Co 215(10g. Citizen of		untry?
ma 23 Louis Jerai	11. Marital Status	IGITO	12. Was Dec	cedent Evar in	U,S. 13.			lispanic Origin? (Sp an, Mexican, Puerto	ecify Yas or No	USA 14. Ra	ca - Amar	rican Indian,
natural, or the	1 Never Married 3 Widowed 4		Armed Food Types If Yas, G	orcas? 2 □ No live Dates\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		if Yes, specify		Specify:	Hican, atc.)	Specia	ick, White fy: Whi	
Strati	15.	. Decedent's	s Education grada completed))	16a. Dece	dent's Usual O	ocup	ation during most of work	rina	16b. Kind of E		
event, the Medical Eng. Be Completed by	Elamantary/Secondar		1	(1-4or 5+)				during most of work		Priso	200	
ပိ	12 17. Fathar's Nama (Firs	st, Middia, L	ast)		Corr	ection	đΙ	Officer 18. Mother's Nam	a (First, Middle,			
ToB	Grover Tra	anum						Helen	Spiker			
aumentic e	19a. Informant's Name	/Ralationsh	ip (Type, Print)		19b. Mallin	ng Addrass (S	treet	and Number or Rui	al Routa Numbe	er, City or Town	, Stata, Z	ip Code)
other tr	Mary Trant			206	17614	McMul	le	n Hyw. R	awlings	Md 21	502	Four Ptate
any injury or or once.	1 DBurlal 2 □ Cı	ramation		Stata	. Place of Dispo cematary, crer		r plac					
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	23a. Part1 Entar tha d	lisaasa, or o	complications that	caused tha de	ath. Do not ent	ar the mode o	rcl f dyin	n St. Ki ng, such as cardiac	or respiratory a	rest,	1538	Approximata
an			my one oddod on	audit mid.								Interval Between Onset and Death
cal ner	Immediata Causa (Fina diseasa or condition rasulting in daath)	al	a	ARC	SALAC	NIA						MINUTES
100				_	(or as a consec	,		-11/				MINUTES
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EX	Sequentially list conditi- if any, leading to immediause. Enter Underlyin Cause (Disease or Injur	diate ng	c								i	
edicai	that initiated events resulting in death) Last		Ų.	Dua to	(or as a conseq	uence of):					i	
cian/Medical Examin			d									
sicia	Part II. Other significan	nt condition	s contributing to d	leath but not r	asulting in tha u	nderlying caus	sa giv	ren in Part I.	23b. Dld	lobacco use co	ontribute	to the cause of death?
by Physician/M	1 -	SIPS			- D.S			2401 711	10	Yes 2 No	3 Pr	obably 4 Unknown
eted										an autopsy med?	8	Wara autopsy findings available prior to completion of cause of death?
Сощр									10	ras 30 No	1	Yas 25 No
Be	25. Was casa rafarred t	to medical	A1				100	26. Place of Deal	th (Check only o	ne)		
the funeral director, Ication: To Be (1 Yes 2 No		Hospital: 1 28a. Data	11111111111111	ER/Outpatier		Oth	4 LI Nursing Ho	oma 5 Rasio			cify)
tion		☐ Pending invastigs	(Mon	nth, Day Year)	Injury	м 200.	Injur Wor	k? Yas 2 □ No	200. 0000000	iow injury occu	1100	
5 %		Could no datamin	ot be 28a. Place	e of Injury - At ling, etc. (Spe	homa, farm, str	eet, factory, of	ffice		28f. Location (S City or Tox	Street and Num yn, Stata)	ber or Ru	ral Route Number,
Medical Cert	29a. Certifier 15 (Check only one)	Certifying Medical E	kaminer: On tha b	a best of my k basis of axami	nowledge, death nation and/or Inv	n occurred at to vastigation, in	ha tin	na, data and place, pinion, death occur	and dua to tha red at the time,	cause(s) and m data and place	annar as , and dua	stated. to the cause(s)
completely filled Medical Ce	29b. Signatura and titla	of certifier)	101	<i>C</i>	29c. Li	icens	e number		29d. Data sign	ed (Month	n, Day, Year)
77		1	DEET 1	LOVA	2	•	D	31879	5	July	12, 1	999
	30. Nama and addrass of											
	Robert Wo			02 Seto		, Cumb	er.	land, MD	21502			
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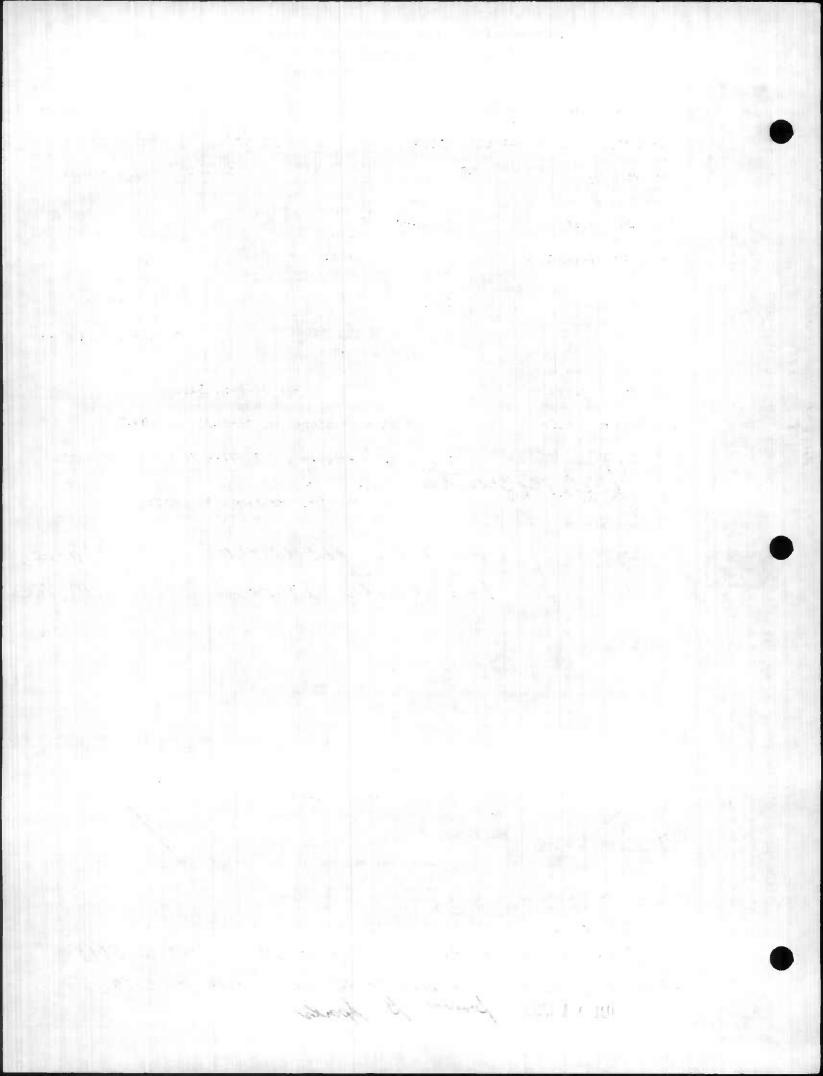


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middle, Last)						2. Date of Death 3.					
Physician /Medical	PHILIP L. TAYLOR							Jh LY	Day	2200		
Examiner	4a Facility Na	ma (If not Institution, giv	re street and number)				4b. City, Town, or		4c. County	of Death		
	PENINSULA REGIONAL MEDICAL CENTER						SALISBU	SBURY WICOMICO				
uneral rector	498-03-8380 **C M 2 F 89 Yrs. Months					dar 1 Yaar ns Days						
ž	10a. State	ce of Decedent 10b. County		10c. City, Tox	wn or Location					10d. Inside City Lin		
faho lor	Delawar	e Sussex		Seafo	rd.					1, Yes 2		
si', or items 23s or 28s-f show Exercines must be notified at by Funeral Director		10e. Street and Number				10f. Zip Code				/hat Country?		
	1001	1001 Middleford Rd				19973			US			
ther must for must Funeral							Decedent of Hispenic Origin? (Specify Yes or, specify Cuban, Mexican, Puarto Rican, etc.)			- American Indian,		
"natural", or its potcal Exercise leted by Fu				XXYas 2 No		Yes 2 No Specify:			Black, Whita, etc. Specify: White			
ted for		15. Decedent's Ed	ducation	cation 16e. Decedent's			t's Usual Occupation d of work done during most of working NOT usa retired) .butor			siness/industry		
then dmc	,	Secondary (0-12)		College (1-4or 5+)						rial Products		
44 6	17. Fathar's No	ame (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	t, Middle, Meiden Sumeme)			
	Harry	G. Taylor					Beatri	ce M. Sm	nith			
r is marks traumatic To		t's Name/Relationship (Type, Print)	19	b. Meiling Addr	ess (Stree	end Number or Ru	ural Route Numbe	er, City or Town,	Stete, Zip Code)		
22		ylor - wife	9				ford Rd,					
t: if item 2 y or other		f Disposition 2 Cramation 3 Close 5 Other (Specification)			of Disposition (in any, cremetory of the control of		erv 7	Data /17/99 E		City or Town, State , Illinois		
important: if item any injury or othe once.	21. Signature o Fyheral Servic icensed 22. Name and Addrass of Facility Cranston Funeral Home P O Box 967, Seaford, DE 19973											
ysician	23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
edical miner	Immediate Cause (Finel disease or condition resulting in deeth) BILATERAL PNEUMONIA. Due to (or as a consequence of): ALZHIEMERS DISEASE								1 WEEK			
ē			11	Due to (or as a	consequence	of):	DICE	ACE		In VE		
n and ial-transit Examiner	Conventinity II	at conditions	b		consequence		VIDE	75/-		10/FH		
	Sequentially II if any, leading cause. Enter Cause (Disea: that initiated e	to Immediate Underlying se or injury	С	550 to (6) 50 to 60,004,000 0.7.								
0 6	that inflated events resulting In death) Last Due to (or as a consequence of the consequ					of):						
for use a												
by the tached	Part II. Other eignificant conditions contributing to death but not resulting in the u				In the underlyin	derlying cause givan In Part I. 23			o. Did tobacco use contribute to the cause of dea 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unkn			
b ed d												
should should									as an autopsy deformed? 24b. Were autopsy available prior completion of of death?			
page 2								101	res 21/No	1 ☐ Yes 2 ☐ No		
tor, p	25. Was case	referred to medical					28. Place of De	ath (Check only o	na)			
tifica tor. p	examiner?	2 No	Hospital: 1 Inpatie	ent 2 ER/C	Other					esidence 6 Othar (Specify)		
ractor ractor	27. Manner of Death Staturel 5 Pending Accident Investigation		28a. Ate of Injury (Month, Day Year) 28b. Time of Injury M			28c. Injury at Work? 1 Yes 2 No			be how injury occurred			
After this certific funeral director, tion: To Be			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Routa Numb City or Town, Stata)					
After this certific funeral director, tion: To Be	Nature	le 6 Could not b			29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, for the basis of examination and/or investigation, in my opinion, death occurred and manner stated.							
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Ne Funeral Director: After this certific pletely filled in by the funeral director edical Certification: To Be	2 Accide 3 Suicid 4 Homle 29a. Certifier (Check on one)	6 Could not be determined	ysician: To the best of	ехапплалоп в	ndoi investigat	ion, in my 1 29c. Licen	se number	J	29d. Date signed	d (Month, Dey, Year)		
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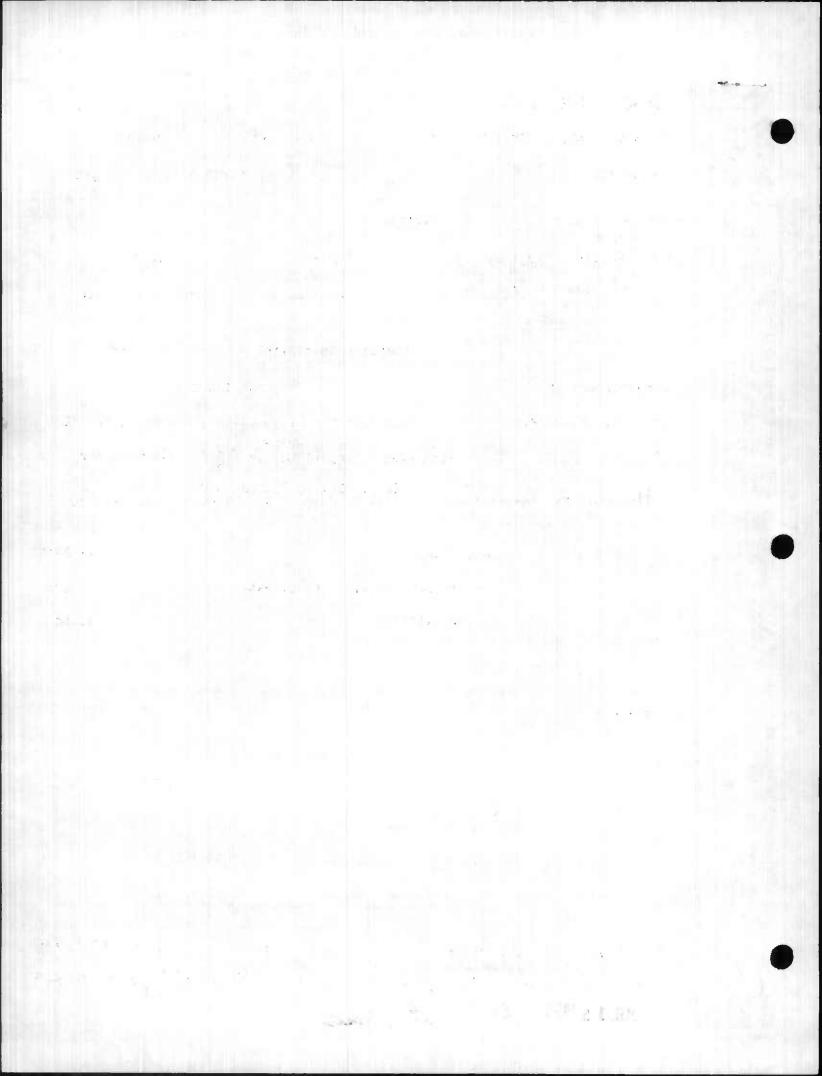
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State of Maryland / Department of Health and Mental Hygiene 99 23860

				Certificate of	f Death		Reg. No.	lue lue	0000		
Summer to the	1. Decedant's Nama (First, Middle,	2. Dete of D Month	eath Day	Yeer	3. Tima of Death						
Physician /Medical	IVOOOFFF FFF	July			7:20 PM						
Examiner	An English Alama (Mana Ingla Alama)			4b. City, Town	n, or Location of Dea 1 a	th 4c. County of Death Howard					
Funeral Director	097-14-7623	6. Sex 7 1 Ø M 2 □ F	Aga (In yrs. lest bir 75	hday) If Under 1 Ya Months De		Min. (Month, D	irth 18, <i>Year</i>) 8,1924		ce (Stete or Foreign y) inia		
r 28a-f show Inotified at	10a. Stata 10b. County					own or Location					
with the period of the contract of the contrac	10e. Street and Number			10f. Zip Cod		10g. Citizan of What Country					
e 23a or must be	10626 Faulkner		2	U.S.A. 14. Race - American Indian,							
5-UUZU 72 hours after death with the Maryland 72 hours after death with the Maryland natural, or items 23a or 28a-4 ahow afted Examiner must be notified at		Armed Force	Yas 2 □ No as, Giva 1 □ Yes 2 🖾 N			Puerto Rican, etc.)	Black, Whita, atc. Specify: Black				
	15. Decedent's (Specify only highast Elementary/Secondary (0-12) 12th		lor 5+)	(Give kind of work do life. DO NOT use re	nt's Usuel Occupation ind of work done during most of working O NOT use retired) Duter Specialist			16b. Kind of Business/Industry Government			
and 212 dbe filed within mitel Hygiene. ed other than event, tha M	17. Fathar's Neme (First, Middla, Li Benjamin Walke	Lest) 18. Mother's Nem					ne (First, Middle, Melden Sumeme) A Thornton				
Maryland nd 2 should be file the and Mentel Hy 27 is marked other traumatic event	19e. Informant's Name/Raletionshi	p (Type, Print)		Malling Address (Str 626 Faulkr	eet and Number	or Rural Routa Num	ber, City or Town				
Baltimore, Maryland 212 semit. Peges 1 and 2 should be filed withi Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than ange. To Be Comm	20e. Method of Disposition 1 🔀 Burial 2 🗆 Cramation 3 4 🗆 Donation 5 🗇 Other (Spe	3 □Ramoval from St	20b. Plece of cemeter	Disposition (Nema or y, cremetory or other aptist Churc	oleca) Cemete	ery Dete	20c. Location	- City or Tow			
Baltimor permit. Peges Department of I Important: If ite any injury or of	21. Signature of Funeral Service Licensee Nancy A. Percenti 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785										
Physician	23a. Part1. Entar the se, or c shock, or heer failura. List o	omplications that cau	used the death. Do rich line.	not enter the mode of	dying, such es ce	ordiac or raspiratory	errast,		Approximate Interval Batwaen Onset end Deeth		
/Medical	Immediate Causa (Final disease or condition	Lu	ng Cancer						l½ years		
Examiner	resulting in daeth)	0	Due to (or as a consequence of):								
		Chronic Obstructive Lung Dise							Years		
X 68 (60, shifting the executed is as the bunaritansit Medical Examiner	Sequentially list conditions, if eny, laading to immadiete cause. Enter Underlying Ceuse (Disease or injury that initieted events	Due to (or es e consaquence of): Hypertension Years									
BOX 68/6U, leath certificate be exe attending physician e I for use as the burial.	that initieted events rasuiting in daath) Last	d	Dua to (or as a consequance of):								
_ 2 6 60	Pert II. Other eignificant condition	s contributing to dea	th but not resulting Ir	the undarlying cause	given in Pert I.	23b. Did	i tobacco uea co	ontribute to	the cause of death		
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aw requires to the second of t							erformed? avi		e autopsy findings lable prior to plation of ceusa eath?		
The law ate hes t page 2 s						10	Yes 2 No	10	Yes 2□ No		
Physician: The Physician: The this certificate ral director, page: To Be Co.						f Death (Check only	one)				
_ 2 2 2	1 ☐ Yes 2 No	Hospitel: 1 🖄 Inj		tpatient 3 DOA		ing Home 5 ☐ Res					
DIVISION O To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: ?		ation	(Month, Dey Year) Injury Work? I □ Yes 2 □ No				28d. Describe how Injury occurred				
DIVISIO Mal or Attendi urs efter death. rai Director: A lied in by the fi	4 Homicide determined building, etc. (Specify)					City or To	28f. Location (Street and Number or Rural Routa Number, City or Town, State)				
To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funeral Medical Certification	29e. Cartifiar (Check only one) 29e. Cartifiar (Check only one) Add Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the ceuse(s) end menner as stated. 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s end manner stated.										
To the comple	29b. Signeture end title of cartifier	s Pel	29c. License nur			290 pg 25/0		d. Data signed (Month, Day, Year) +444 / 15 / 1999			
(1)	30. Name and address of person w	ho completed cause	of deeth (Item 23e)			allicott .	CA	MT -	21042		
State	31. Deta filed (Month, Dey, Year)	10 32 Reg	gistrer's Signeture	COII CAT I	<i>N</i> ∓ (U :	CHICON	uy	IV D	X IO 7 J		
Registrar	JUL 1 5 199	S COM	0	South							



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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** 8, 1999 8:45 PM **JEANNE** WADE 4b. City, Town, or Location of Deeth /Medical 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Prince George's Lanham 9217 4th Street If Under 1 Yeer | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2√2 F Yrs. November 5, 1917 Washington, D.C. Director 578-28-3638 Usuei Residence of Decadent 81 the Meryland r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□ Yes 2□ No Directo Maryland Prince George's Lanham 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Baltimore, Maryland 21215-0020

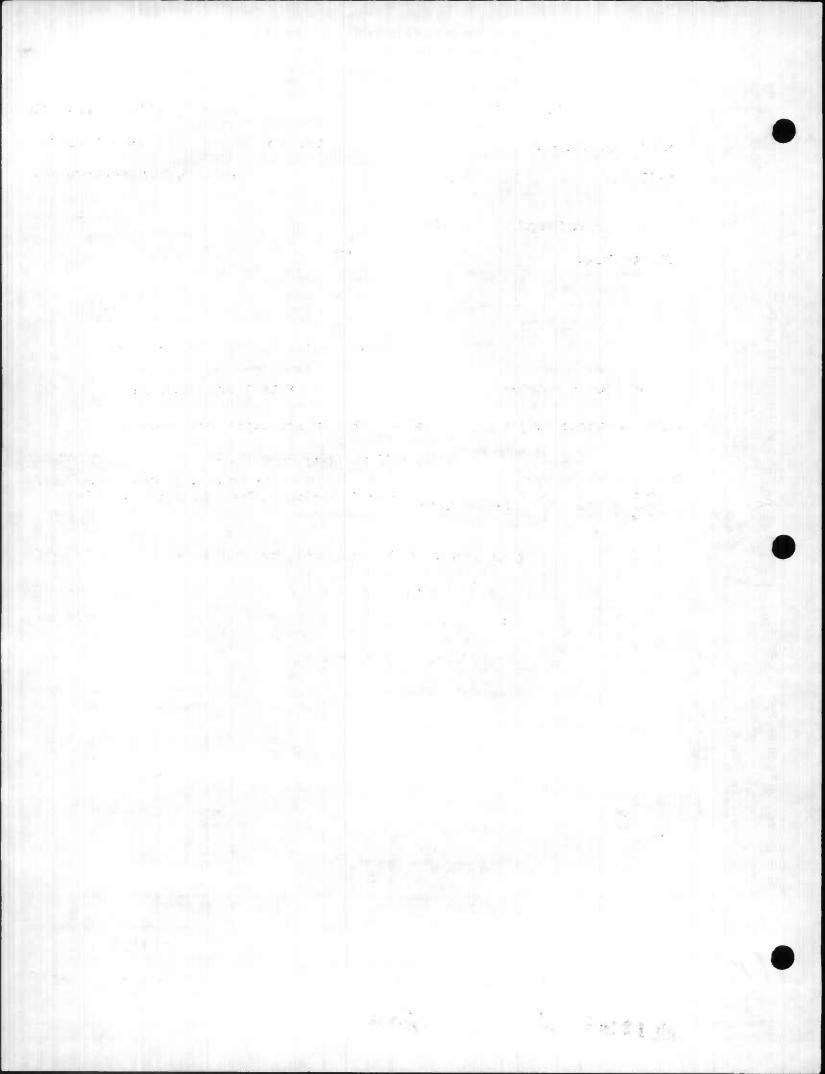
emit. Peges 1 and 2 should be filed within 72 hours effer death with to Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Westerl Evarine mental pance. 20706 U.S.A. 9217 4th Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Meritei Stetus Bieck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 XNo Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Sales Clerk Beauty Shop 8 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Robert Mallory Spicer Eula Blanche Humphrey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Ditoto/Daughter 14704 Cambridge Dr. Upper Marlboro, MD 20772 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition XX Burial 2 Cremetion 3 Removel from State Cedar Hill Cemetery July 12,1999 Suitland, MD 20746 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4111 Pennsylvania Ave. Suitland, MD 20746 elace Int. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faill re. List only one called on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Atherosclerotic Heart Disease Examiner Examiner Failure Renal physician and the burial-trensit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last Due to (or es a consequence of) that the death certificate be exec 7 20 years petension Box 68760. Physician/Medical Due to (or es e consequence of) use as t Mellitus ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed page 2 s has 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes ⊉ No 10 this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: Affer Neturei 5 Pending after death. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7/9/99 D37934 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Coreenway Center Dive Greenbelt 10 26770 Trifoslio MD 7500 Stephanie 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

Registrar

DHMH 16 Rev 6/95 JUL 1 76

General B. Sports



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	1. Decedent's Na	ma /First Mida	lla i ast)		Ce	rtificate c	or Death		2. Data of Deat	ng. No.		3. Tims of Death
Physician /Medical	М	AE BEL	L WILL				T 41 Chu To		JULY	09,	Year 1999	0520AM
Examiner	4e Facility Name	RINER H		number)				TIMOR	ation of Deeth	4c. County	IMORE	CITY
Funeral	5. Sociel Security		6. Sex		s. last birthday)	If Under 1 Ye	ear If Undar		8. Data of Birth (Month, Dey,			ece (Stete or Foreign
Director	219-10-		1□M 2 X	F 79	Yrs.	MORRIS	sys Hours	TVIII.	2-28-	20	North	Carolina
Le notredat	Usuai Residence 10a. Stata	10b. County	y	10c. 6	City, Town or Lo	ocation					10	Od. Insida City Limits
28a-f ahow nothing at	MD.	BALT1	MORE CI	гу	BALTIM	ORF						1 X 1 Yes 2 □ No
be notified Director	10e. Street and N		THORE OI		DILLITI	10f. Zip Cod	ie		10	0g. Citizen of	Whet Coun	try?
ral C	2854	Bookert	-			212				U.S		
Funeral	11. Merital Stetus	rried 2 ☐ Mai	Arme	Decedent Ever in d Forcas?	U,S. 13.	Was Decedant of Yas, specify C	of Hispanic Or Cuban, Mexica	igin? (Spec n, Puerto R	cify Yas or No- lican, etc.)		ce - Amarica ck, Whita, e	
by		4 Divorce	If Yes	as 200 No , Give or Detas:		1□ Yes 🎾	No Specify:			Specif	Blac	ck
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omple	Elementery/Sec	condary (0-12)	Ī	ge (1-4or 5+)				, 0	9	N/A	A	
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dury jury		5 Other (G	arrison				/14/99	Baltin	more,	Md.
important: If any injury or pnce.	21. Signature of F	-uneral Service	Licensee	207 -	7	THE HO	USE OF		IAMS			
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D 20									24e. Wes e	n eutopsy	24b. We	ere autopsy findings
should should									perform	med?	COL	allable prior to mpletion of ceuse desth?
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9 0 0	25. Wes case refe	erred to medica	ai				26. Plac	e of Deeth	(Check only on			Λ
rtificate hartor, page	examiner?	X No	Hospitel:	□ Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 N	ursing Horr	ne 5 🗆 Reside	ence 8 🗆 Ot	her (Specif)	()
rector, rector			28a. D	ate of Injury Month, Day Year)	28b. Time o Injury		Injury at Work?		8d. Describe ho	ow injury occu	rred	
his certific if director.		eth 5 🗌 Pendi	ng "			M	1 ☐ Yes 2 ☐	No				
his certific	1 Yes 2	5 Pendi invest	igation	lace of Injuny - At	home ferm st	reet fectory off	lice	2	8f. Location (St	reet end Num	ber or Rura	l Route Number.
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State Registrar

31. Date filed (Month, Pay 2 1999

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Box 68760 P.0. 3 Division of Vital Records, peed has cartificata this After t To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After aftar daath.

2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** HARVEY LEWIS WILT JULY 6, 1999 5:00 AM 1 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 417 E. GREEN STREET OAKLAND GARRETT If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) OCT 18 1910 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (Stete or Foreign **Funeral** Deys 1MM 2□ F Months Hours 88 MARYLAND 216-07-9647 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No MD GARRETT Director OAKLAND 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 417 E. GREEN STREET 21550 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, 11. Maritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Haalih and Mental hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Hedical Eurorine pages. Black, White, etc. 1 ☐ Never Merried 2 X Merried 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE P 3 Widowed 4 Divorced Year or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME CONSTRUCTION CARPENTER 18. Mother's Neme (First, Middle, Meiden Sumeme) 17 Fether's Neme (First, Middle, Last) ZELPHIA **JOHN** ALBERT WILT MABEL BLOCHER 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) 415 DENNETT ROAD OAKLAND, MD 21550 WAYNE WILT - NEPHEW Baltimore, 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burlel 2 Cremetion 3 Removel from State 7/9/99 OAKLAND CEMETERY OAKLAND, MARYLAND 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name end Address of Fecility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 M00167 Approximete Intervel Between Onset and Deeth 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final YEARS PROSTATIC CA disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner that the daath certificata be axecuted the attending physician and hed for use as the burial-tran-Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieled events resulting in deeth) Last Due to (or es e consequença of): Physician/Medical Due to (or es e consequence of) 23h. Did tobacco use contribute to the cause of deeth? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown à 2 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? Completed completion of cause of death? page 2 TO Yes 212 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 💆 Residence 8 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by tha funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stele) 28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) end menner stated. 29a. Certifier Medical completaly (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier JULY 6, 1999 H26154 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 0 69 WOLFE ACRES DR. OAKLAND, MD 21550 DANIEL MILLER, D.O.

State

Registrar

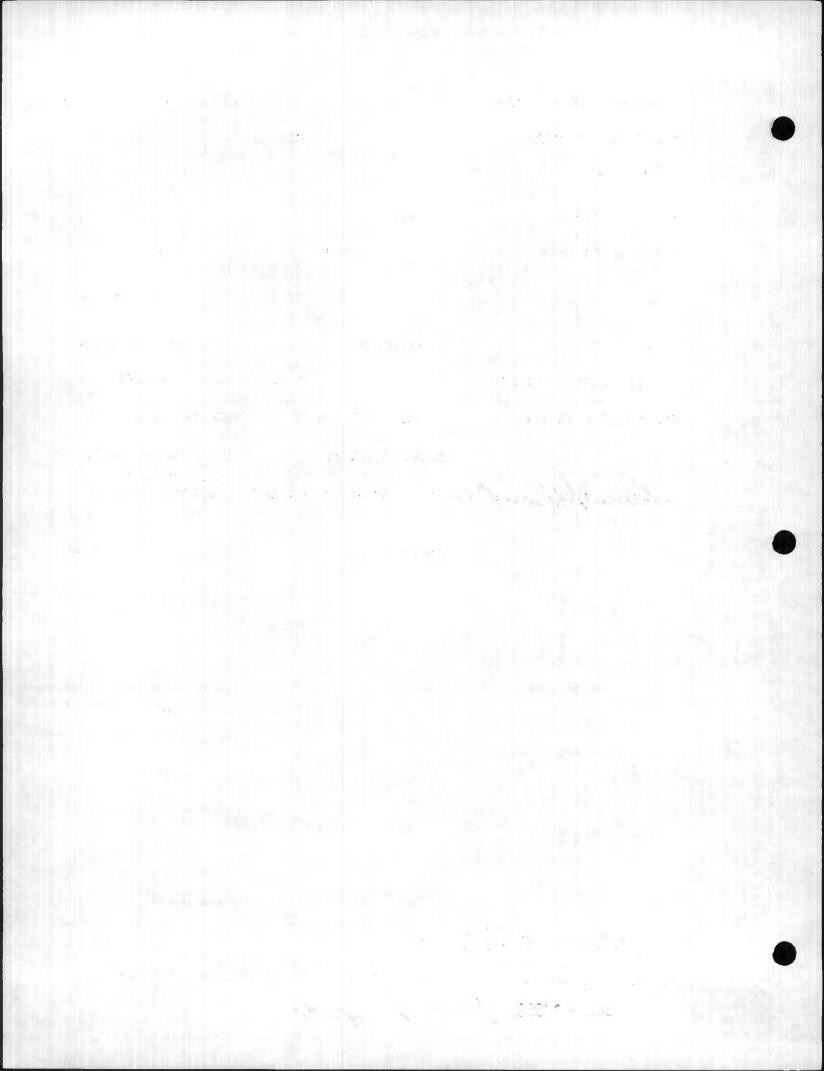
31. Dete filed (Month, Dey, Year)

JUL

- 7 1999

32. Registrer's Signeture

borely



DAMIEN WORKMAN

ne or Print in Black Indelible ink Assure All Conles Are Legible Please Typ

pe of Fillt ill black illuelible lik. Assule All copi	ICO VICE	egible.				
State of Maryland / Department of Health and Mental	Hygiene	99	23	86	51	00 11 00
Certificate of Death	Reg. No.					

Physician
/Medical
Examiner

1. Decedent's Neme (First, Middle, Last) Damien Joseph Workman

4a Facility Name (If not institution, give street end number)

2. Dete of Death Day Month JULY

4b. City, Town, or Location of Death

8,

4c. County of Deeth

3. Time of Death 0510 AM 1999

Funeral

Director

r flore 23a or 28a-f ahow liner must be notified at 8

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other trai

Baitimore, Maryland 21215-0020

Physician /Medical Examiner

Hospital or Attanding Physician: The law requires that the death certificate be executed 88 F þ Be Completed page 2 certificate completely filled in by the funeral director, Medical Certification: To After this within 24 hours after death. To the Funeral Director: A

Division of Vital Records, P.O. Box 68760,

	JOHNS	HOPKINS H	OSPITAL					BALT	'IMOF	Œ	Bal	timor	e
	5. Sociel Security 217-37-	7588	ex 7. /	Age (In yrs. Ia 6	st birthday) Yrs.	If Under Months	Deys	If Under Hours	Min.	8. Dete of Birth (Month, Day, 12/3/19	Year)	9. Birt	thplece (State or Foreign puntry) yland
	Usuel Residence			1.0.00							-		
	10a. Stete	10b. County			Town or Lo	cation							10d. Inside City Limits
200	Md.	Somerset		Cris	field								1 □ Yas 2 No
9	10e. Street and N	lumber				10f. Zip	Code			1	0g. Citizen	of What Co	ountry?
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Laner	11. Meritel Stetus		12. Wes Deceder Armed Force 1 Yes 2	nt Ever in U,S	. 13. V	Ves Dece I Yes, spe	dent of H cify Cube	lispanic Or an, Mexica	rigin? (Sp n, Puerto	pecify Yes or No- Rican, etc.)	14.1	Rece - Ame Black, Whit	erican Indian, e, etc.
2	AL	4 □ Divorced	If Yes, Give Yeer or Detes		1	☐ Yes	2 No	Specify	:		Spe	ecity: W	hite
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_	-	Name/Relationship (ral Route Number			
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	21. Signature of	Funeral Service Licen	Wats	200	22	. Neme er	nd Addre	ss of Fecil	ity	e, Mills			
	shock, or h	r the disease, or compeen leilure. List only	olicetions thet caus one ceusa on each	ed the deeth. line.	Do not ente	er the mod	de of dyir	ng, such es	cardiac	or respiretory erro	est,		Approximate Interval Between Onset and Deeth
	disease or condi resulting in deet		a	LIT	161			- 1	17	mic	2		
e				Due to (or a	as A)conseq	uence of):							
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AL.													
YSIC	Part II. Other sign	nificant conditions o	ontributing to death	but not result	ing in the ur	nderlying o	cause giv	ren in Pert	1.	23b. Did to	bacco uss	contribute	to the cause of death

o the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

1 PYes

24b. Were autopsy lindings evailable prior to completion of cause of death. 1 DYes 2 No

25. Was case referred to medical axaminar? 1XXes 2□ No 27. Menner of Death

5 Pending investigation

6 Could not be determined

2 ER/Outpatient 3 DOA Inpatient 28b. Time of Injury Year Un Known

28c. Injury at Work? 1 Yes 2 2 No

O.C.M.E

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 29d. Describe how injury occurred ian Struck by vehicle

rsou

2 No

29a. Certifier (Check only one)

1 Neturel

2 Accident

3 Suicide

4 Homicide

At home, lerm, street, lectory, office por

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29c. License number

26. Place of Death (Check only one)

29b. Signature end title of certilier

29d. Date signed (Month, Dey, Year) JULY 9, 1999

28t. Location (Street and Number or Rural Route Number, City of Town, State)

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

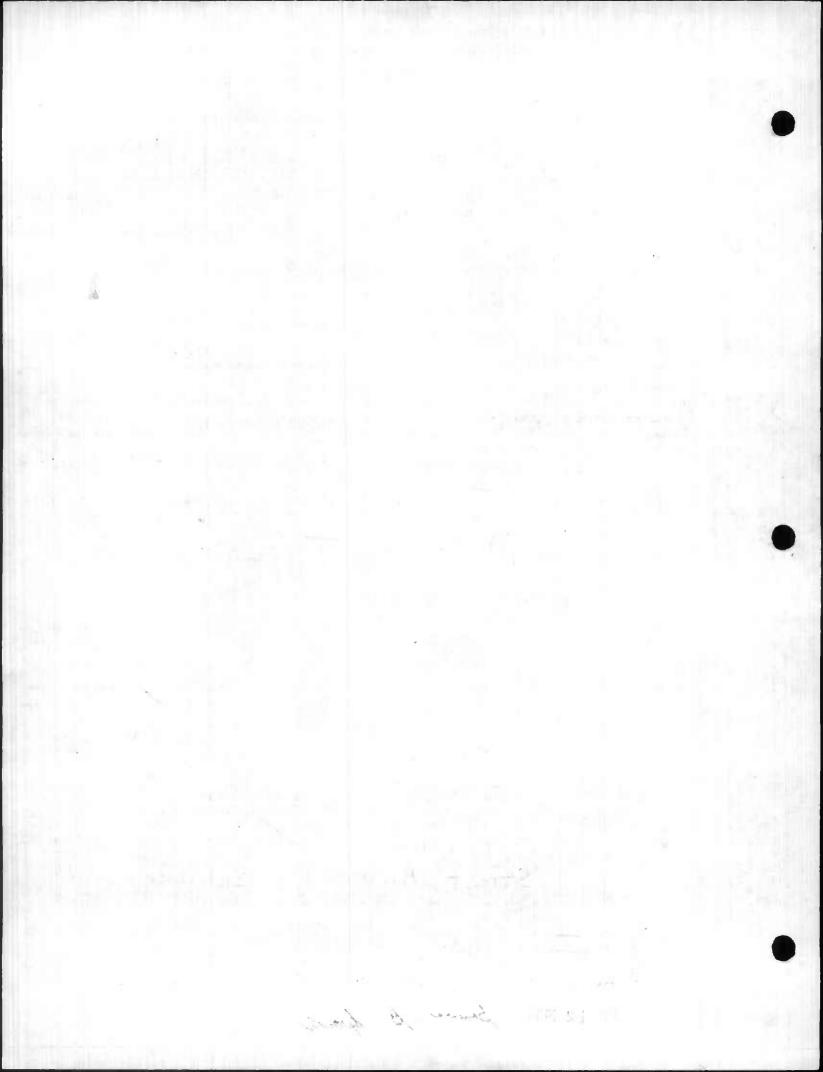
estamer 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete liled (Month, Dey, Year) 12 1999

32. Registrer's Signeture

Sporti



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anna Winder 10 Jul 0615 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SALISBURY
If Under 24 Hrs.
Hours Min. WICOMICO PENINSULA REGIONAL MEDICAL CENTER 7. Age (In yrs. last birthday) 59 Yrs. If Under 1 Year Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 250 F Months Days Hours Yrs. Director 218-40-5005 July 27, 1939 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland neat of health and Mental Hyglene.
Intri. If term 27 is marked other than "natural", or items 23s or 23s-f show any or other traumatic event, the Medical Experies must be noticed at any or other traumatic event, the Medical Experies must be noticed at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 516 Rose Street 21801 U.S. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Security Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Corbin, Sr. Clara Farlow 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Saunders-Davis/daughter 2-12 Four Seasons Parkway, Newark, DE 19702 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If its any Injury or o 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens 7/17/99 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shorts, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Car disease or condition resulting in death) Examiner Examine physician and s the burial-transit the death certificate be executed hoe of); Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Physician/Medicai Due to (or as a consequence of) Rest usa as t signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has b 1 ☐ Yes 2 €No 1 TYPS 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Monation 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this funaral 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After 5 Pending Investigation 1 DNatural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours after Funeral Dire lately filled in b after Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Hosp within 24 hos To the Fune complately fi edical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 25209 7-10-99 30. Name and add ese of person who completed cause of death (Itam 23a) (Type, Print) John MchEAN 106 Milford St.

DHMH 16 Rev 6/95

State

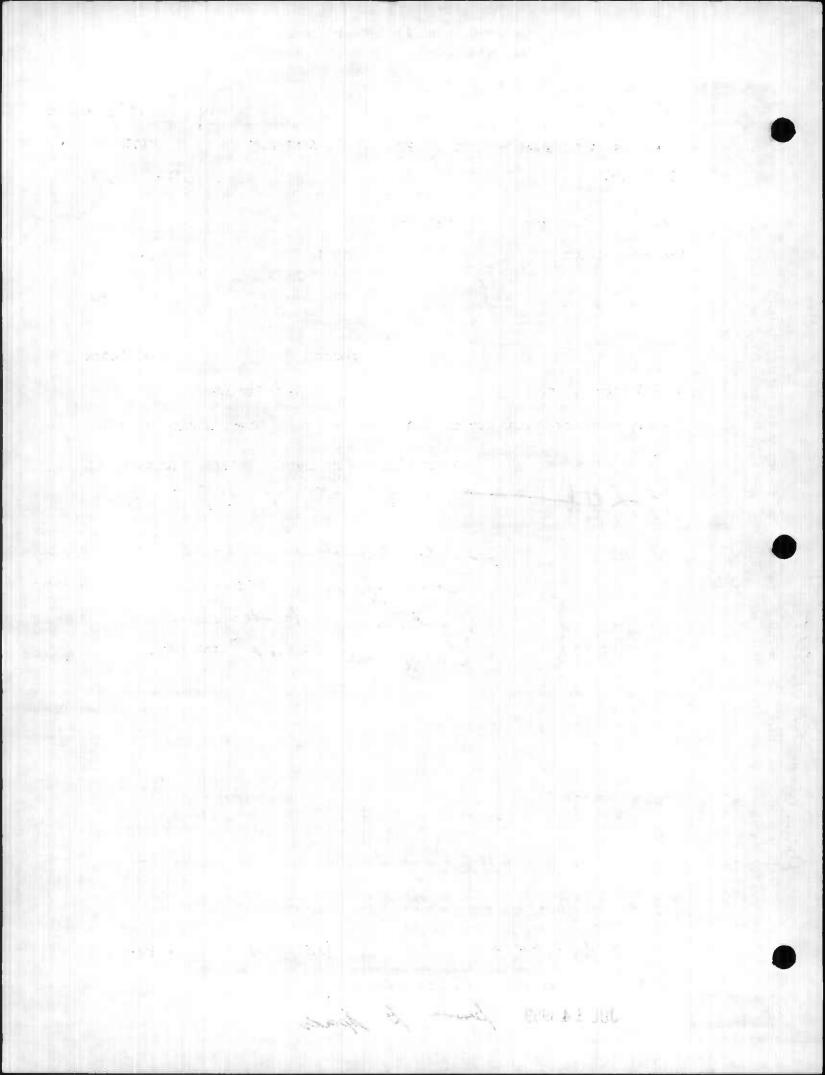
Registrar

31. Date filad (Month, Day, Year)

JUL 1 4 1999

32. Registrar's Signature

Winder 218-40-5005



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death Month Day **Physician** ROSA YOUNG. July 11, 1999 9:50pm /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5501 Lancing Dr. Camp Springs Prince George's If Under 1 Yaer If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 578-32-2743 1□ M 2⊠ F 75 15, 1924 Denwiddie, Co. Va Director Jan. Usual Rasidence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow edical Examiner must be notified at Maryland Prince George's 1 ☑ Yas 2 ☐ No Director Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5501 Lancing Dr. 20746 United States death Funeral 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: Pages 1 and 2 should be filed within 72 hours after on or Health and Mental Hyglene.
Int: If item 27 is marked other than "natural", or Neury if you other traumatic avent, the Marian 1 Nevar Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elamentary/Secondary (0-12) Federal Government Administrator Assistant 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Waverly Bailey Mary Pegram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) William Hunter/Son 5302 Manchester Dr. Camp Springs, Md. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Stoney Creek Cemetery 17/22/99 Stoney Creek, Va. 22. Name and Address of Fecility
Alexander S. Pope Funeral Homes 21. Signature of Funeral Service Licenses ollas 5538 Marlboro Pike/Forestville, Md. 20747 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tntarval Between Onset end Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Car Cigencetosin mns. Examiner Examiner 8 mms metastatic endometrial physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): cors Box 68760 endo me trial Physician/Medicai cancer Dua to (or as a consequence of): 980 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 □ No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Nasidence 6 Other (Specify) 1 No 2 No this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: Aftar Division 1 Natural 5 Pending investigation a 24 hours after death.

Funeral Director: After sleeply filled in by the fun 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number tuon MD 45274. July 12, 1999 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) Cho Maung, M.D. 10810 Connecticut Ave. Kensington, Md. 20895 31. Data filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23867 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Time of Death 35 ALSUP Jul ARNELL KICARDO 4b. City, Town, or Location of Daath 4e Facility Neme (If not institution, giva street and number, 7. Age (In yrs. lest birthdey) / If Under 1 Year ALTIMORE MARIS If Under 24 Hrs. B. Data of Birth (Month, Day, Year) Min. MARCH 5, 1951 Birthplece (State or Foreign Country) 5. Social Security Number N 2□F Months Days Yrs. UNKNOWN Usual Rasidance of Decedant 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 X Yas 2 □ No 10e. Street end Number 10g. Citizen of What Country? 1616 USA. 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Give Yaar or Datas: Race - Amarican Indian. 11. Marlfal Stetus Black, Whita, atc. 1 □ Navar Marriad 2 □ Marriad 1 Yas 20 No Specify BLAC 3 ☐ Widowed 4 🎖 Divorced 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) BLAST FURNACE 12 +H GRADE SPARROWS POINT 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fethar's Name (First, Middla, Last) BERGER 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 834 CARROLL STREET BALTIMORE, MD. 2/230 ce of Disposition (Nama of Dete! 20c. Location - City or Town, State (SISTER) DARLENE ALSUP 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from Stata CEDAR HILL CEMETERY 07-30-99 BALTIMORE, MARKAND 21. Signatura of Funerel Solving Licensed 22. Nama and Address of Facility 23. Nama and Address of Facility 24. Nama and Address of Facility 25. Nama and Address of Facility 26. Nama and Address of Facility 27. FUNERAL HOME 27. Full Town Ave., BALTO, MP. 21217 28. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximeta 4 □ Donation 5 □ Other (Specify) Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or es a consequance of) Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Causa (Disaase or Injury that initiated evants rasulting in deeth) Last Due to (or es e consequence of): Dua to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Anknown 24b. Wara autopsy findings aveilable prior to 24a. Was an autopsy complation of causa of death? 2 0 No 1 Yas 2 No 1 Yas

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

Director

Funeral

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Completed

Be

Funeral

Director

item 27 is marked other than "natural", or itsma 23a or 28a-1 show other traumatic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic avent, the Modeal Examinations.

Baltimore, Maryland 21215-0020

the Maryland

with

death

that the death certificate be exec

Hospital or Attending Physician:

To the

Division of Vital Records, P.O. Box 68760

attending physician and for use as the burial-tran detached

Examiner

Physician/Medical 2 Certification:

þ Completed Be

the signed by 8 peen page 2 s has certificate this funeral : After t within 24 hours after death. To the Funeral Director: Al filled in by

> State Registrar

edical

(Check only one)

MARIS AT MERC 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) STE //A Other: 4 Nursing Home 5 Rasidance 6 Nother (Specify) HOS DICE 1 Yas 25 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Daath 28d. Dascribe how Injury occurred 28h Time of 28c. Injury ef Work? 5 Panding invastigation 1 Delatural 2 Accident 1 ☐ Yas 2 ☐ No 281. Location (Street and Number or Rurel Route Number, City or Town, Stata) 6 Could not be determined 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifian

Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

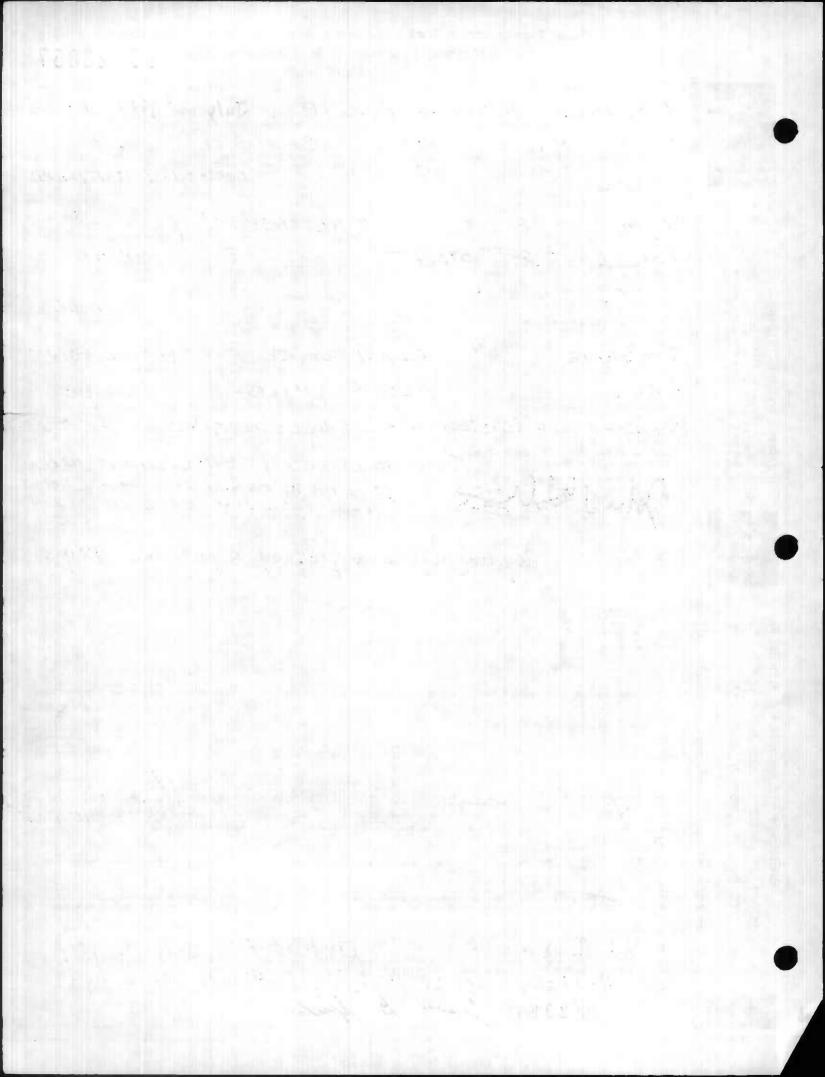
| Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

29d. Date signad (Month, Day, Year)

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

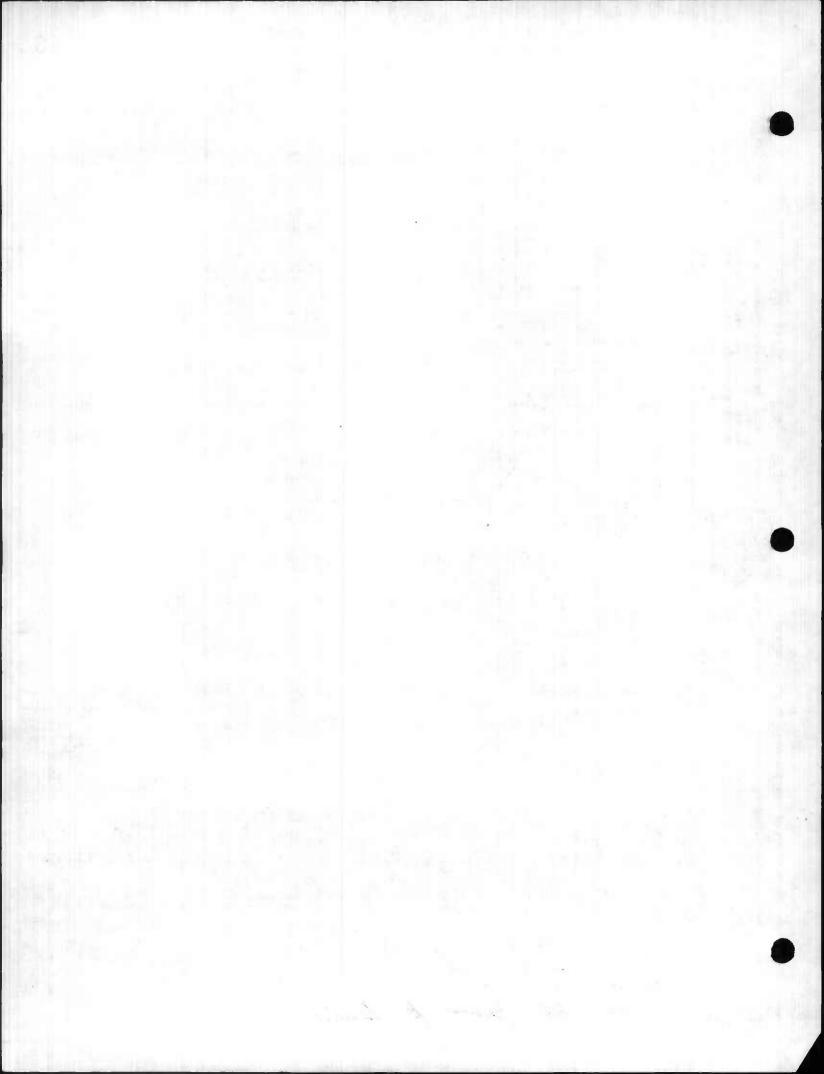
RAHIMORE

32. Registrar's Signature 1999



State of Maryland / Department of H	lealth and Mental Hygiene
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		Certificat	e of Death	Re	g. No.	
	Decedent's Neme (First, Middle, Last)			2. Date of Death	1	3. Time of Death
Physician (Mandian)	Lester Bernard Artis			July	26 1999	6:28 P.M.
/Medical Examiner	4a Facility Neme (If not institution, give street and number)		4b. City, Town, or		4c. County of Death	
Lxammer	Maryland General Hospital		Baltimore			
Funeral		je (In yrs. last birthday) If Under			9 Birth	oplace (State or Foreign
Director	212-26-5822	71 Yrs. Months	Days Hours Min.	(Month, Day, 05/03/19		hplace (State or Foreign untry) th Carolina
death with the Maryland rms 23s or 28s-f show rms the notified at nersi Director	10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
vith the Ma	Maryland	Baltimore	0.11	100		
a so do		10f. Zip		10	g. Citizen of What Cou	untry?
ath value	727 Druid Park Lake Drive	*	1217		U.S.A.	
5 22 3	11. Merital Stetus 1 Never Married 2 Merried 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Armed Forces? 1 Yes, Give Year or Detes:	If Yes, spec	dent of Hispanic Origin? (S cify Cuban, Mexican, Puerl 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Rece - Amer Bleck, White Specify: B1	e, etc.
2 he	15. Decedent's Education	16a. Decedent's Usua	I Occupation	1	6b. Kind of Business/I	ndustry
Maryland 21215-0020 d 2 should be filed within 72 hours aft th and Mental Hygiene. 'natural', or 77 is marked other than 'natural', or 'traumatic avent, the Medical Exam To Be Completed by F	(Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or	5+) (Give kind of wo life. DO NOT us Truck Dr	rk done during most of worse retired)		Produce	
a filed with Hygien other the vent, the	17. Father's Neme (First, Middle, Last)	TIUCK DI		ne (First, Middle, M		
should be fill and Mental H I merked out urmstic aver	Lester Artis		Cora L.	Read		
Marylar 2 should be 2 should be and Mental is marked or raumatic av	19a, Informent's Name/Reletionship (Type, Print)	40h Mallina Addana			City on Town City 7	En Contol
Ma 12 st 12 st 12 st	19a, Informent's Name/Reletionship (Type, Print)	190. Melling Address	(Street and Number or Ri	urai Houte Number,	City or Town, State, 2	ip Code)
Shan Shan Shan Shan Shan Shan Shan Shan	David Morris / Son 20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ Removel from State	20b. Ptace of Disposition (Nar cemetery, crematory or o	ther place)	7/31/99 ²	Oc. Location - City or T	Town, State
ting Family Family	4 □Donation 5 □ Other (Specify)	King Memorial				wn, Maryland
Baltimo permit. Pages Department of Important: If it any injury or pace.	21. Signature of Funeral Service Lipensee		d Address of Facility Th ark Heights			
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	ROSCLEROTIC Due to (or as a consequence of):	CARDIOVA	SCHLAR	DISEASE	Onset and Death
OX 68 / 60, certificate be associated right physician and use as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):		1 - 2 - 2 - 2		
	d					
death ce attendi	Part II. Other significant conditions contributing to death b	ut not consisting in the contact days	ausa shina ia Dari I	22h Did toh	i de contributo	to the cause of death?
P.O. d by the d by the Setach	HYPERTENSION	ut not resulting in the underlying c	ause given in Part I.			obably 4 Unknown
Ord requir nould hould	CANCER OF K	HONEY		24a. Was an perform	ned?	Wara autopsy findings available prior to completion of cause of death?
The law the law page 2 s	CANCER OF	PROSTATE		1 ☐ Yes	s 20 No 1	I □ Yes 2 □ No
lclen: The certificate rector, pag	25. Was casa referred to medical	, -	26. Place of De	ath (Check only one	3)	
hyalcla hyalcla his car il direct	axeminer? 1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatie	ent 2 ER/Outpatient 3 DC	Others		nce 6 Other (Spec	cify)
VISION OF VITA Attending Physicien: r death. ector: After this certific by the funeral director, lification: To Be (27. Menner of Death 1 Naturel 5 Pending (Month, Da		8c. Injury at Work?	28d. Describe how		1177
5 8 8 5 E	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injurishing, etc.	ury - At home, farm, street, factory	1 ☐ Yes 2 ☐ No r, office	28f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
To the Hospital within 24 hours To the Funeral completely filled Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner street.	examination and/or investigation.				
New Application of the Company of th	29b. Signeture and title of certifier	290	. License number	29	d. Dete signed (Month	i, Day, Year)
- 3 - 0	1 Tomich	nd	D3027	2	July :	28,1999
	30. Name and address of person who completed cause of d		SHINGTON	BLVD	BALTO.	MO 21230
State	31. Date filed (Month, Day, Year) 32. Begistr	ar's Signature	W. 1			



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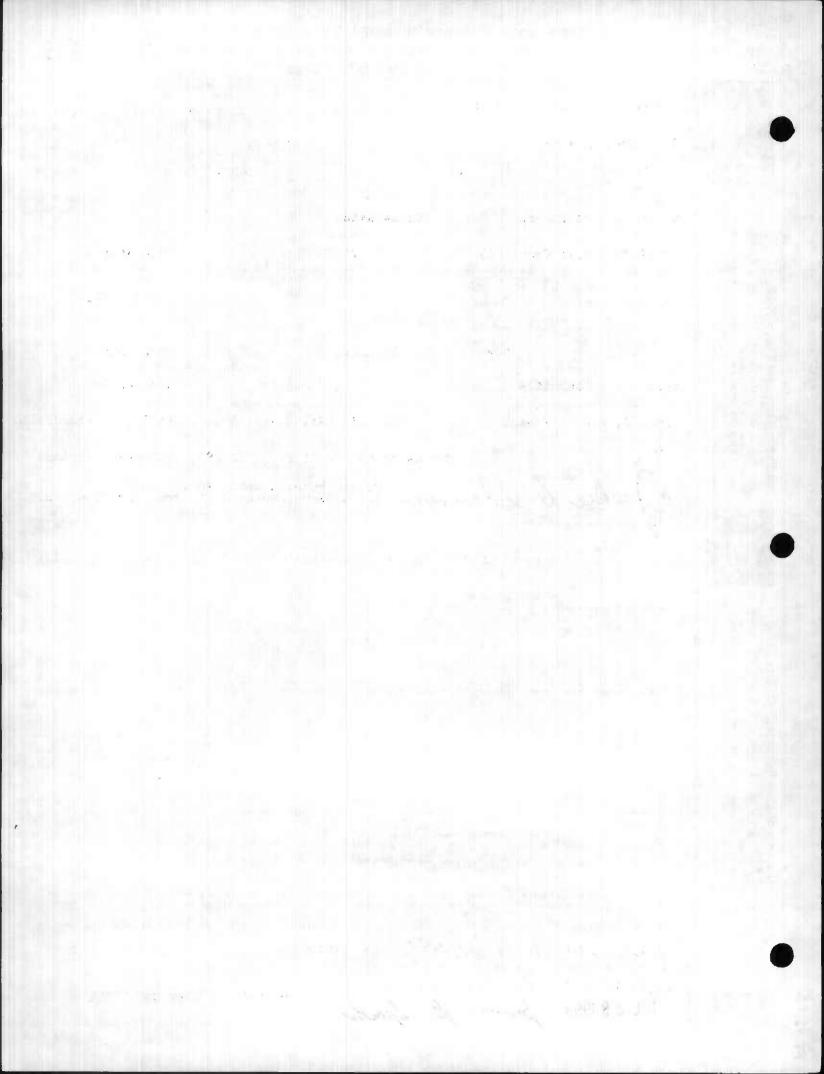
ONS				State of IV	iai yiai i		rtificate				Reg. I	00	4	3009
Г	Physicia	_	1. Decedent's Neme (First, Middle, La Agnes Helen		all					2. Dete of 0 Month	t	Dey	Yeer	3. Time of Deeth
	/Medic Examin		4e Fecility Neme (If not Institution, giv ST. AGNES HOSPITA		7)					TULY or Location of De	eth 7	1999 4c. County	of Death	
	Funeral Director		5. Sociel Security Number 6. S		ige (In yrs. I	last birthdey) Yrs.	If Under 1 Months	Year Deys	BALTIMO It Under 24 H Hours M		Birth Day, Yea	1912	9. Birthp Coun	laca (State or Foreign try) Maryland
	Marylend -1 show	lor	Usuel Residence of Decedent 10a. State 10b. County Maryland Baltim	nore	10c. City	, Town or Lo	ocation nsvill	e					1	0d. Inside City Limits 1 ☐ Yes 2X No
	3a or 28a	al Director	10e. Street and Number 2 Bristoll Hill 0	Court A3			10f. Zip 6	228				Citizen of V		
020	72 hours efter death with the Maryland natural;, or items 23a or 28a-f show sical Examinar must be notified at	by Funeral	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 Yes 2 1 If Yes, Give Yeer or Detes	? [No	S. 13.	Wes Decede If Yes, speci	fy Cub	dispenic Origin? en, Mexican, Pu Specify:	(Specify Yes or I erto Rican, etc.)	No-		e - Americ k, Whita, Wh:	etc.
21215-0020	m 1 3	Completed	15. Decedent's Et (Specify only highest gra Elementery/Secondery (0-12)	ducation de completed) College (1-4or	r 5+)	(Give life.		done retire	pation during most of v d)	vorking	16b.	. Kind of Bu		dustry
nd 21	should be filed within nd Mentel Hygiene. marked other than imatic avent, the M	Be Con	12th 17. Fether's Neme (First, Middle, Last,			Но	memake	r		eme (First, Midd			e)	
Maryland	0000	To	Pius Laukai 19e. Informent's Neme/Reletionship (Type, Print)						Rural Route Nun	nber, Cil		Stete, Zip	Code)
imore,	permit. Pages 1 and Department of Heelth Important: If Item 27 any injury or other tr pncs.		James J. Bonsall/ 20e. Method of Disposition 1 Buriai 2 Cremetion 3 C 4 Donetion 5 Other (Specification of Funeral/Service Licer	Removel from Steto	9 0	lece of Disponentery, cre Cath	osition (Nem metory or oth edral 2. Neme end	e of her ple Cen	ce) netery	Dete	20c. 9 Ba	Location -	City or To	ryland2122 own, Stete Maryland
	Physician /Medical Examiner	Examiner	23a. Perf. Enter the disease, or common or hear feilure. List only Immediate Cause (Finel disease or condition resulting in deeth)	e. Athro	Due to (o	(rofi'd	C C q					ease	2	Interval Between Onset and Deeth
Box 68760,	ficate be physicials to the bur	edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initialed events resulting in death) Lest	c		r es a conse							i	
P.0	the y th	/ Physician/M	Pert II. Other algnificant conditions of	ontributing to death	but not resu	ulting in the u	underlying ca	use gi	ven in Pert i.		id tobec	2 No		o the cause of death bably 4 Unknow
Vital Records,	has been see 2 should	Completed by								Ins		ulopsy 17 10 1 2 × No	ev cc of	ere autopsy findings allable prior to impletion of cause death?
f Vita	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1√2 Yes 2□ No	Hospital:	tient 2X	ER/Outpatie	nt 3 DO	A Ot	hor	Death (Check on Home 5 Re		a 6 🗆 Oth	er (Speci	(y)
Division of	Attending or death. ector: After by the fune	Certification:	27. Menner of Deeth 1 Neturai 2 Accident 3 Suicide 4 Homicide 2 Pending investigatio 6 Could not be determined	e 28e. Piece of I		28b. Time of Injury ome, ferm, s	М		nyat nk?]Yes 2 ☐ No	28d. Descrit 28f. Location City or		t and Numb		al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai C	29a. Certifier (Check only one)	yalcian: To the bes niner: On the basis end menner s	of exeminet	wledge, dee tion end/or in	th occurred envestigetion,	t the ti	ime, dete end pi opinion, deeth o	ece, end due to the time	he caus ne, dete	e(s) and mo and place,	enner as s and dua t	stated. tha cause(s)
	To the To the comple	Me	29b. Signeture end title of certifier Aty M	1 VI	no	4	MD	Licen	se number ME		29d.	Date signe		Day, Year)
			30. Neme end eddress of person who	completed cause of	deeth (Item	1 23a) (Type	, Print)							

Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201
31. Detailed (Month, Day, Year)
32. Register's Signature

4. Sparks

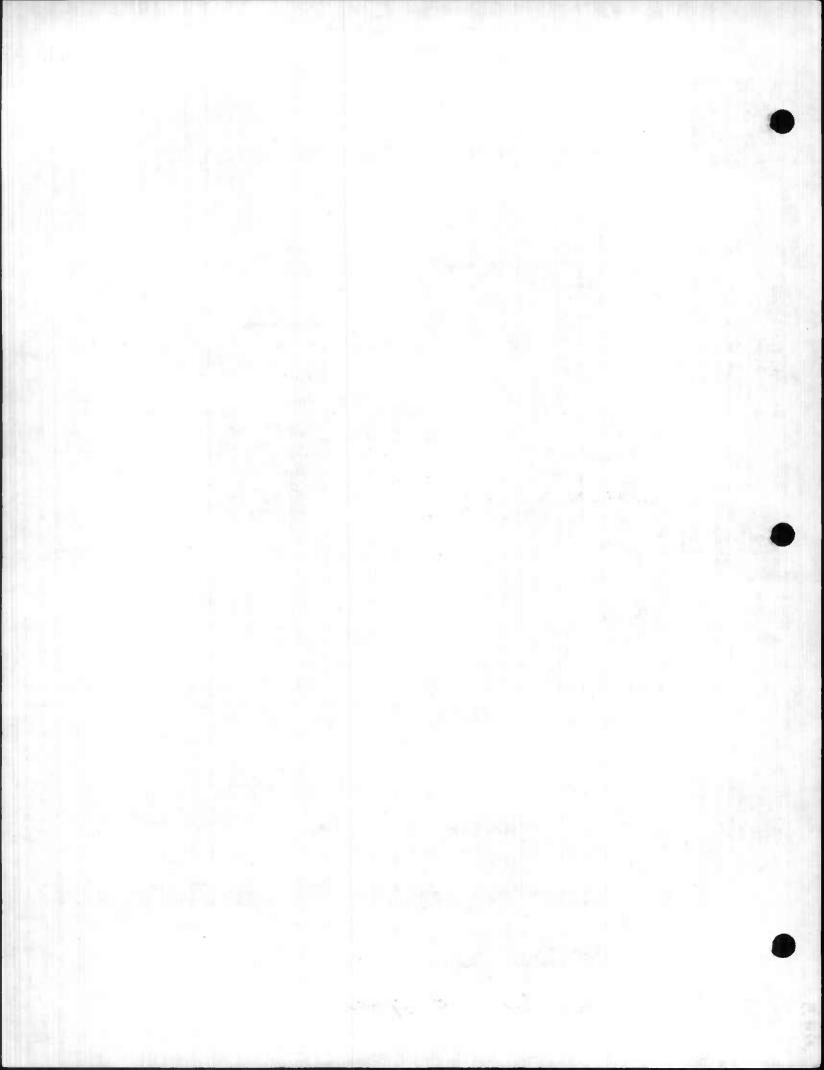
State Registrar

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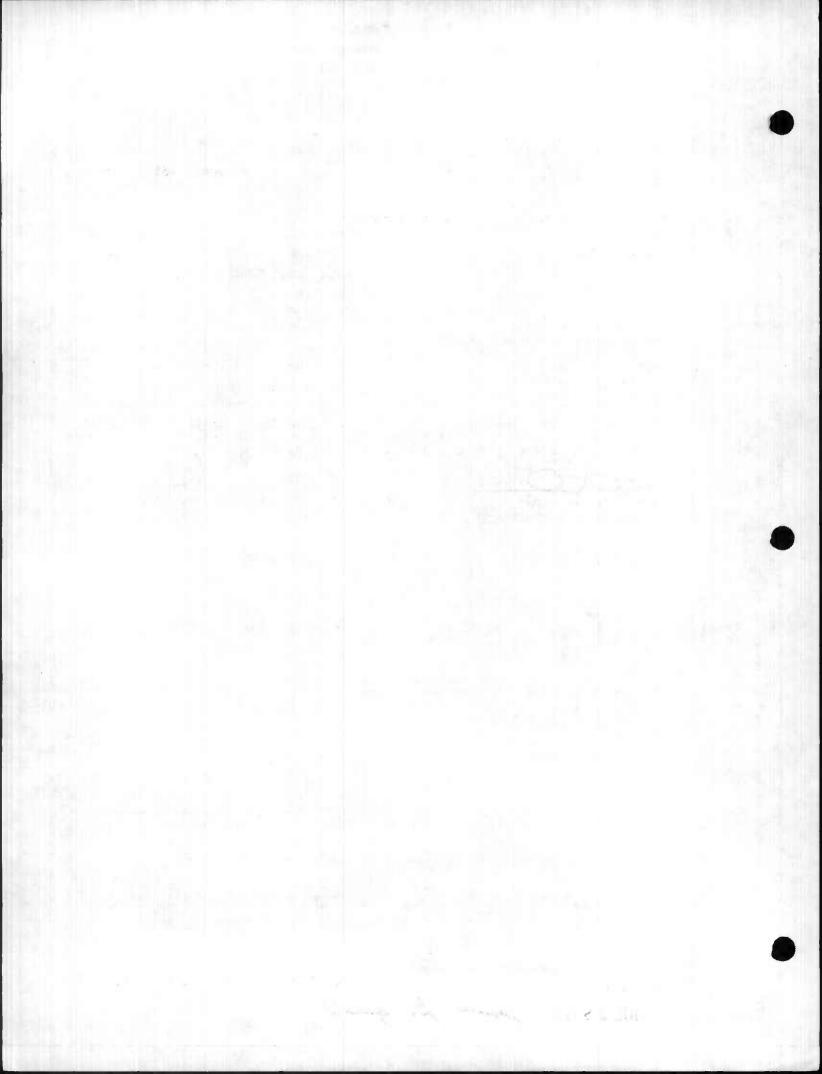
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O.

		1. Decedent's Neme (First, Middle, La.	st)	00/	tificate of	Death	2. Dete of De			3. Time of Death
	Physician /Medical	Carrie Marie	Jones Ba	attle			July 2	2, 1999	Year	1:15pm
	Examiner	4e Facility Name (If not institution, given 2117 North Longo				4b. City, Town, or Baltimore				
	Funeral	5. Sociel Security Number 6. S	ex 7. Age (In yrs	2.4	If Under 1 Year Months Deys		8. Dete of Bir	th Year)	9. Birthpi	lace (Stete or Foreign
E	Director	231-28-4106 1 Usual Residence of Decedent	□м 2√2 F	74 Yrs.			May 0	1, 1925	Rock	y Mount, No
nyland	ahow stat	10a. Stete 10b. County	10c. C	ity, Town or Loc					10	Od. Inside City Limits
he Ma	perfor	MD N/A		Balt:	lmore Ci	ty				1√ Yes 2 No
th with t	r Herra 23a or 28a-fa niner mant be notified Funeral Director	10e. Street end Number 2117 North Lohgs	wood Street		10f. Zip Code	21216		United		•
filed within 72 hours after death with the Maryland	b l	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes ZZONo If Yes, Give Year or Detes:		/as Decedent of I Yes, specify Cub ☐ Yes 20No	Hispanic Origin? (S ean, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	14. Race Black Specify:	k, White,	an Indian, etc. Lack
within 72 ho	la Hygiene. d other than "naturi avant, the Medical avant, Be Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondery (0-12)	Lucetion de completed) College (1-4or 5+)	(Give k	ent's Usuel Occupind of work done O NOT use ratire	during most of wo	rking	16b. Kind of Bu		
pelij ed p	avant, Be Co	17. Father's Name (First, Middle, Last) James Jones				-		, Maiden Sumami errell	9)	
end 2 should be	= 01 L	19a. Informant's Name/Relationship (1 Emma Jones Hill (and Number or Rid Avenue	ral Route Numb		State, Zip 2322	
Φ.	2 5 6	20a. Method of Disposition 1 Burial 2 Cremation 3x 4 Donation 5 Other (Specify	Removal from State	Place of Dispos cemetery, crem lity Cer	atory or other pla	July 2	Date 9, 1999	20c. Location - ROCKY		
permit.	important: If insport	21. Signature of Funeral Service Licen	See Victor P. Doda	CI	Neme end Addressinaries L	Stevens Fort Ave	Funera enue, Ba	1 Home, 1timore	Inc. Mary	land 21230
Ph	ysician	23a. Part1. Enter the disease, or companies, or heart failure. List only	plicetions that ceused he dee one cause on each line.	th. Do not ente	r the mode of dyi	ng, such es cerdie	or respiretory a	rrest,	1	Approximete tnterval Between Onset and Deeth
	Medical aminer	Immediate Cause (Finel disease or condition resulting In deeth)	a. Due to (or as e consequ	ience of):	cana				3 mos.
be executed	physician and s the burlet-transit edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or es e consequ	ence of):					
deeth certificata be executed	Ch. 65	that initieted events resulting in death) Last	Due to (d	or as e consequ	ence of):					
deeth	d by the attending stached for use a Physician/M	Part II. Other eignificant conditions or	ontributing to death but not re	sulting in the un	derlying ceuse gi	ven in Pert I.	23b. Dld	tobacco use con	tribute to	the cause of death?
that the						3-1111	10	Yes 2□No	3 Prot	ebly 4 Unknown
law requires that	should eted							an autopsy ormed?	EV8	ore autopsy findings allable prior to appletion of cause death?
PE.	page 2						10	Yes XXIVO	10	Yes 3500
Physician:	s certificate director, par To Be Co	25. Was case referred to medical examiner? 1 Yes 2000	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	all box of	har	ath (Check only	one) dence 6 □Othe	or /Specifi	4)
9	6 = -	27. Menner of Death Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo			how injury occum		,
200	as after deem. at Director: After to deem by the funeral Certification:	3 Sulcide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, stre	et, fectory, office			Street and Number wn, Stete)	er or Rura	l Route Number,
• Hospit	To the Funeral Di completely filled in		ysician: To the best of my known iner: On the basis of examine end menner steted.							
To th	To the	29b. Signeture end title of certifier			29c. Licen			29d. Dete signed		Day, Year)
		gran	MD		20	40850 Well A		July	22,	1999



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0	me (First, Middla,	Last)			rtificate of		2. Data of De	Reg. No. ath	3.	Tima of Death
Samue		J.		Barr,	Sr		Month	Day	Year 1999	9:26 AM
		give street and nu	mber)	Dull ,	DI.	4b. City, Town, or	July Location of Deat			
	.c Genera	al Hospit	al			Berlin		Word	cester	
5. Social Security	Number 6	6. Sex M M 2 ☐ F	7. Age (In yrs.		If Under 1 Yea Months Days			th Year)	9. Birthplace	(Stata or Foraign
165-32-1	1007	14A.JM 2LJF	5	/ Yrs.	months Day	Tiours in	Feb. 26	, 1942	Lebano	on, PA
Usual Rasidence	of Decedent 10b. County		10c Ci	ity, Town or Lo	cation				104 1	Inside City Limits
	Lebar	202			nville					Yas 2 No
PA 10e. Street and N Palm C3 11. Menital Stetus 1 Never Ma		11011	3	outh Al	10f. Zip Code			10g. Citizen of V	What Country?	
Polm Ci	Lty Lot 2	220				17003			USA	
11. Merital Stetus		12 Wee Dec	edent Ever in U	J,S. 13. 1		Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No	- 14. Rac	e - American Ir	ndian,
	rried 2X Marrie	Armed Fo	2 🔼 No ve		f Yas, apecify Cu 1 ☐ Yes 2 🛣 No		rto Rican, etc.)	Specify	ck, Whita, atc. v: Whit	:e
(Spi	15. Decedent's	s Education		16a. Deced	lent's Usual Occ	upation	netine	16b. Kind of Bu	usiness/Induatr	у
Elementary/Sec		grada completed) College (1-4or 5+)	life.	DO NOT use retir	e during most of wo red)	AKING			
11		N/	A	Brid	lge Insp	_			elding	
17. Father's Nema							me (First, Middle,		_	
Robert	A. Barı						stance G			
	Name/Relationshi					et and Number or F				
Suzanne 20a. Method of Di	M. Barr	/Wife	20h		City Lo	t 220 Sc	outh Anny	20c. Location -		
1 🗆 Burial	2 Cremation 3	3 Removal from	State Gra	nd Vie	matory or other p	al Park	July 31			
	5 Other (Spe						1999	An	nville,	PA
176	nael J. J.			Le		neral Hom onia Road				inc.
			aused the dae	th. Do not ent	ar tha mode of d	ying, such as cardid	c or respiratory a	rrest,		proximate rval Between
resulting In death	,		Dua to (
Sequantially list of if any, leading to cause. Enter Unc Cause (Disease of that initiated ever rasulting in death	IIS T	b cА	Myoc Dua to (o there Dua to (o	or as a consequence of a r d r d r d r d r d r d r d r d r d r	uence of): LL Cu uence of): Aic Ca uence of):	mponac pture ndiovas	cular	diseas	e	
Cause (Diseasa of that initiated even rasulting in death) Last	d	Dua to (c	or as a conseq	uence ot):					
Cause (Diseasa of that initiated even rasulting in death) Last	b	Dua to (c	or as a conseq	uence ot):		23b. Did			cause of death?
Cause (Diseasa of that initiated even rasulting in death) Last	d	Dua to (c	or as a conseq	uence ot):		23b. Did	tobacco use co	ntribute to the	utopsy findings ble prior to stion of cause
Cause (Diseasa of that initiated even rasulting in death) Last	d	Dua to (c	or as a conseq	uence ot):		23b. Did 1 □ 24a. Was perfo	tobacco use co Yes 2□ No an autopsy	ntribute to the 3 Probabl	utopsy findings le prior to stion of cause h?
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Cause (Diseasa of that initiated even rasulting in death Part II. Other sign 25. Was casa refa axaminar? XIS Yas 2 27. Mannar of Det 12 Accident 3 Suicide 4 Homicide 29s. Carifier (Check only one)	arred to medical No ath 5 Pending invastiga 6 Could no datermin	Hospitel: 1 1 28a. Data (Mon bl be led 28a. Place buildi	inpatiant 2E of Injury th, Day Year) of Injury - At h ng, atc. (Speci	Self-ing In the understand the under	ndarlying causa of the state of	26. Place of Do Nother: 4 Nursing ury at ork? Yas 2 No e	23b. Did 1	tobacco use co	ntribute to the 3 Probabl 24b. Ware a availab comple of deat 1 Pve per (Specify) med per or Rural Ro annar as stated and due to the	y 4 Unknown uutopsy findings le prior to stion of cause h? s 2 No uuta Number, causa(s)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month :13am Braden Anus 1 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death EASTBARRY AUS MD BALTIMORE CITY BALTIMA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) - 1 M 2 □ F Months Days 220-38-920 Dec.13,1940 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No n/a Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5304 Eastberry Ave. 21206 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Black. 1 Yes 2 No Specify: Specify. 3 ☐ Widowed 4 🗓 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Mail Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Samue1 Edwin Brogden, Sr. Palestine Simmons 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Denise Brogden / Daughter 654 E. 37th St., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Green Mount Crematory 7/29/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. Your 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Eni ir the disease, ir complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Finel / une an disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Callulins resulting in death) Last 23b. Did tobacco use contributs to the causs of death? Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2/2/No 3 Probably 4 Unknown 1 Yss 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Deeth Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident

Box 68760,

Examiner ettending physician Physician/Medical as the t 980 signed by I by Completed After this uneral Certification:

Physician

/Medical

Examiner

Director

Funeral

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Director

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2 should be filed within 72 hours after and Mentel Hygiene. Is marked other than "natural", or ite

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum

Physician /Medical

Examiner

altimore, Maryland 21215-0020

ician end burial-trans or Attending 24 hours after death. Hospital

Division of Vital Records, P.O. To the Within 2

**Priffying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

3 ☐ Suicide

Medical

State Registrar 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date sloned (Month, Day, Year)

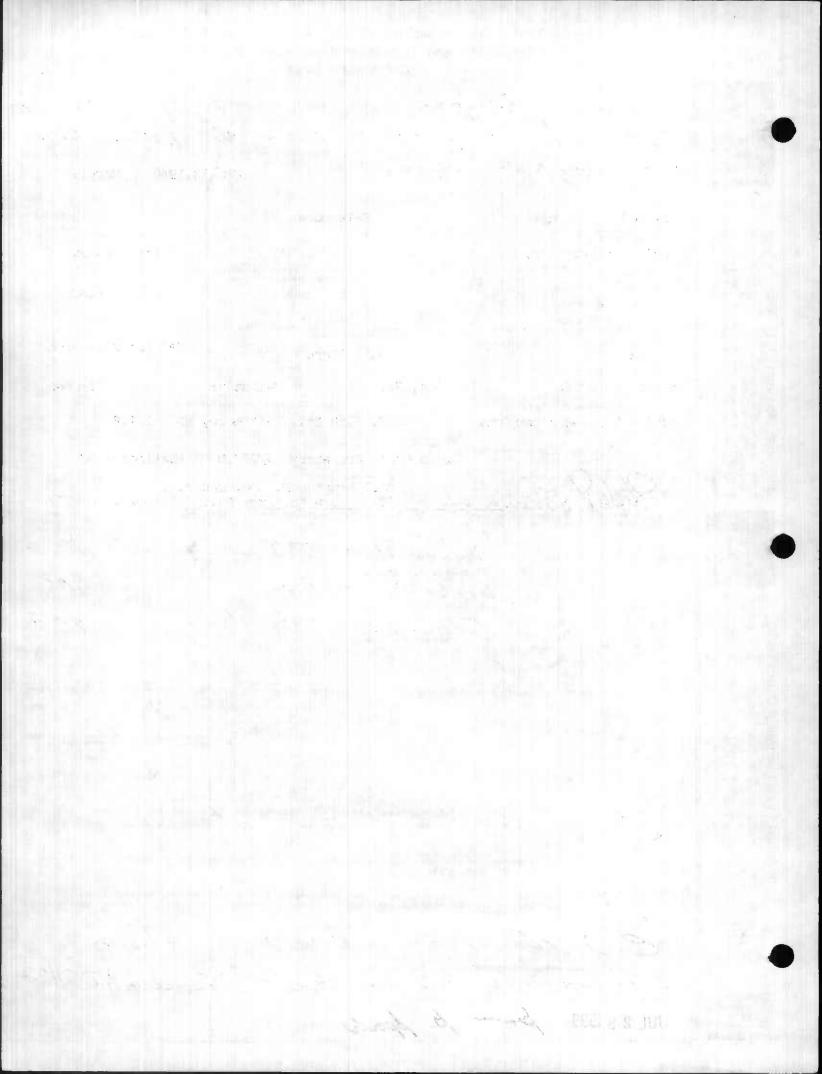
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.O

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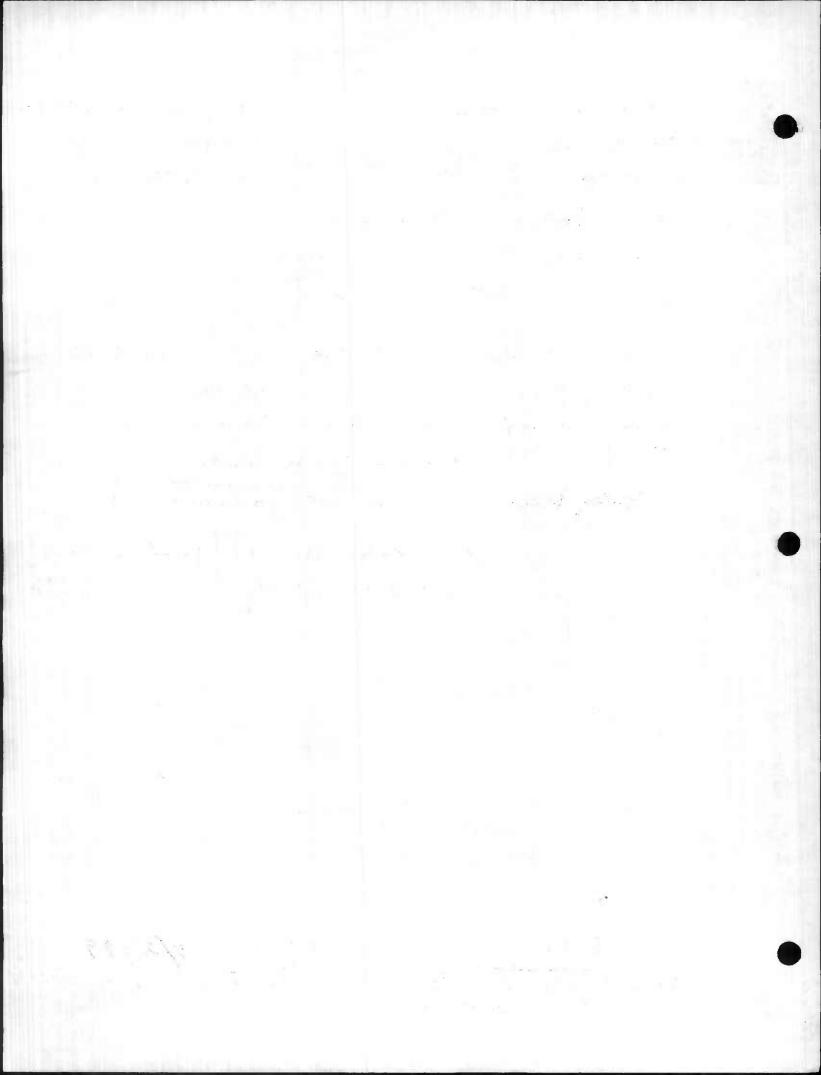
32. Registrar's Signature



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State of Maryland / Department of Health and Mental Hygiene 2 3 8 7 3

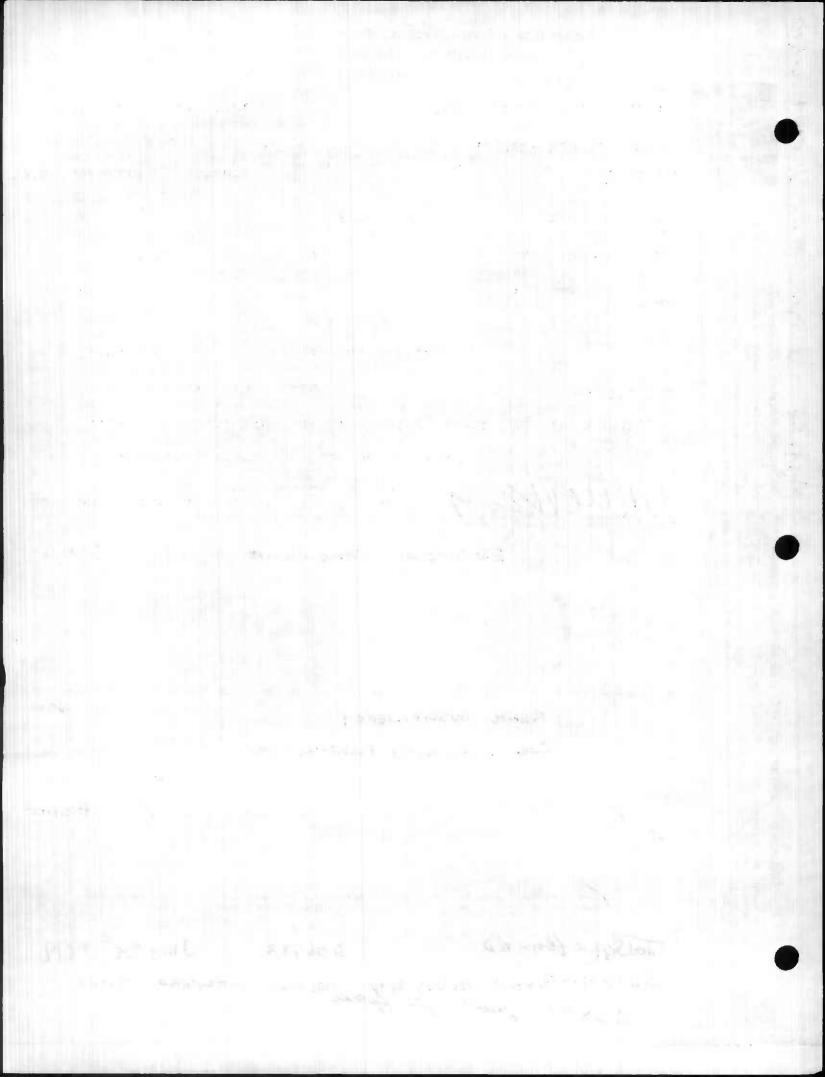
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Please Type or Print in Biack indelible ink. Assure Ail Copies Are Legible. 23874 State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 28 JULY 1999 MATTHEW HERMAN COLEMAN SR. 6:00am /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** BALTO. JOSEPH RICHIE HOSPICE If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 72 Yrs. 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** 1**7** M 2□ F Months Director 8-03-26 239-30-8134 KINSTON. N.C Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examines must be notified at TYP Yes 2 No N/A BALTIMORE md Director Warre for 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 2702 KEYWORTH AVE APT. TO8 21215 U.S.A. Funeral 14. Race - Amarican Indian, Biack, White, etc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No if Yes, Give Year or Dates: 1 □ Navar Marriad 2 □ Married Specify: BLACK 1 Yes 2 No Specify: à ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) d 2 should be filed within 7; in and Mental Hygiena. 7 Is marked other than "nu Elementery/Secondary (0-12) College (1-4or 5+) TEXTILE WORKER RENTEX CORP. 6 18. Mother's Nama (First, Middla, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Be BERTHA MAE DAVIS LEVI COLEMAN athen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is m any injury or other traum ABIGAIL COLEMAN (DAUGHTER) 2910 ELGIN AVE, BALTIMORE, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST 8-3-99 OWINGSMILLS, MD 21 Signature of Funeral Service Licenta 22. Nama and Addrass of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 ons that causad the daath. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death or haart failura. List only ona cause on each **Physician** /Medical Immediate Cause (Final diseasa or condition resulting in death) 2 YEARS ESOPHAGEAL CARCINOMA Examiner Due to (or as a consequence of) Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as e consequence of). 90 Physician/Medical Due to (or as a consequence of): 950 23b. Dtd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 onknown RENK INSUFFICIENCY þ 24b. Were eutopsy findings avellabla prior to 24a. Was an autopsy Completed peen CHRONIC OBSTRUCTIVE PULMONARY OLGENSE completion of causa of death? has 1 Yes 2 No 1 Yas 2 No Division of Vital 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Nother (Specify) HOSPICE 1 Yes 2No To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of tnjury (Month, Day Year) uneral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending 1 Yes 2 No death. Investigation 2 Accident or Attend after death Director: 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 24 hours a 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

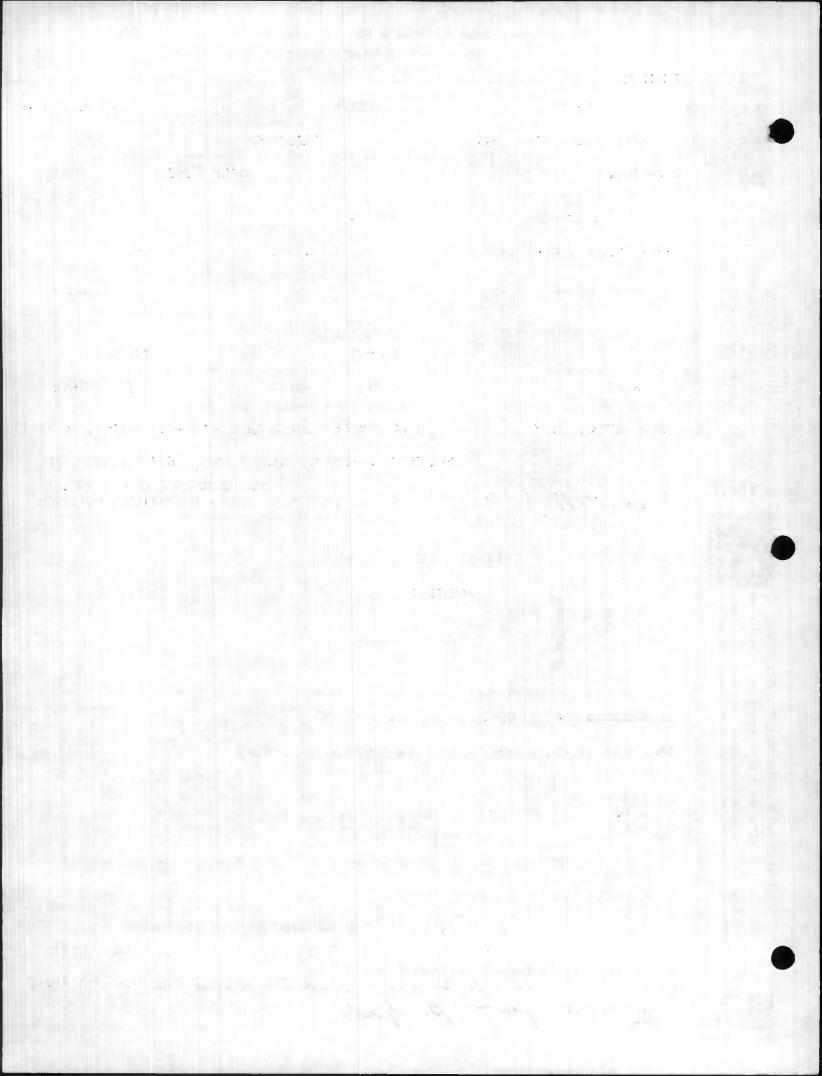
2 Medical Examtnar: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifian 29c. License number D 06933 and address of person who completed cause of death (Item 23a) (Type, Print) JOHN B MAC GIBBON 101 WEST READ ST BALTIMORE MALYLAND PORTS 21201 31. Date filed (Month, Day, Year) JUL 2 9 1999 32. Registratic Signature

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

As Facility Name (If not institution, give street and number) LEVINDALE HEBREW HOME As Facility Name (If not institution, give street and number) LEVINDALE HEBREW HOME BALTIMORE N/A 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Months Days Hours Min. Month, Day, Year) 9. Birthplace (State or Foreign Country) Country) Output Provided the country of Death As Country of Death		1. Decedent's Name	NUSIN	7_29_99 J.			DIZIK		2. Data of C Month	Day	Year 1999 11.10
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ALLA DIZIK / WIFE 1906 RAMBLING RINGE LANE #201 - BALTIMORE, MD 2120 20b. Place of Disposition of Burlar Data 20c. Location - City or Town, Stata 4 Donation 3 Plannyral from Stata 20c. Decision - City or Town, Stata 4 Donation 5 Dother (Specify) 21. Signature of Funeral Sarvice Licenspee 22. Amen and Address of Facility 7/25/99 REISTERSTOWN, MD 22. Same and Address of Facility SOL LEVINSON & BROS. , INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pliffit, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate flustrate Between the Control of Pikes Part 1mmodata Cause (Final dease) Central Fall LURE 25. Due to (or as a consequence of): 1mmodata Cause (Final dease) Due to (or as a consequence of): 26. Legislating in death) Legislating in death but not rasulting in the underlying cause given in Part I. 27. Legislating in death) Legislating in death Legislating in death Legislating in death 28. Wes as inferred to medical systems 28. Wes as inferred to medical systems Legislating in the underlying cause given in Part I. 28. Wes as inferred to medical systems Legislating in the underlying cause given in Part I. 28. Wes as inferred to medical systems Legislating in the underlying cause given in Part I. 28. Wes an eutopsy performed? 28. Wes an eutopsy performed? 28. Wes an eutopsy performed? 28. Wes a en eutopsy performed? 28. Wes a en eutopsy performed? 28. Data of Injury 10 Yes 2 No 28. Place of Death (Check only ona) 28. Place of Death (Check only ona) 28. Place of Death (Check only ona) 28. Place of Death (Check only ona) 28. Place of Death (Check only ona) 28. Place of Death (Check only ona) 28. Place of Death (Check only ona) 28. Place of Death (Check only ona) 28. Death of Injury 28. Divide 28. Death of Injury 28. Divide 28. Death of Injury 28. Divide 28. Divide 2			0.11	,				MARIA		N	IKOLIEVSKY
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) DEEM DONALD 6:05PM 26 1999 344 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth CENTER BALTIMORE NORTHWEST HOSPITAL RANDALLSTOWN 7. Age (In yrs. lest birthday) | fl Under 1 | Yeer | if Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 9. Birthplece (State or Foreign HOM 20 F Yrs. 12-13-28 214-26-9592 SHINNSON, VA Usuel Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A MD BALTIMORE X□Yes 2□No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNKNOWN UNKNOWN U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Detes: 14. Rece - American Indien, Bieck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, apecify Cuban, Mexicen, Puerto Rican, etc.) 11. Meritel Stetus 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) UNKNOWN UNKNOWN UNKNOWN 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JAMES DEEM OPAL HIGEN BOTHEN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) MRS. BOLYARD, P.O.BOX 189 GRAFTON, W. VIRGINA 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, State 20e. Method of Disposition Burial 2 Cremetion 3 Remove from Stete GARRISON FOREST 7-2-99 OWINGSMILLS, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signal re of Funeral Servi a) ensee 22. Name end Address of Fecility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 ert1. Enter the disection of complications that cause the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) · ANOXIC ENCEPHALOPATH Due to (or es a consequence of): CORONARY ARTERY Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es a consequence ot) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown DEMENTIA 24a. Wes en eutopsy performed? 24b. Were autopsy findings available prior to PREUMIONIA completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28d. Describe how injury occurred 28b. Time of

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r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

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Division of Vital Records,

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Registrar

31. Dete filed (Month, Dey, Year) JUL 2 9 1999

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one)

🔼 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

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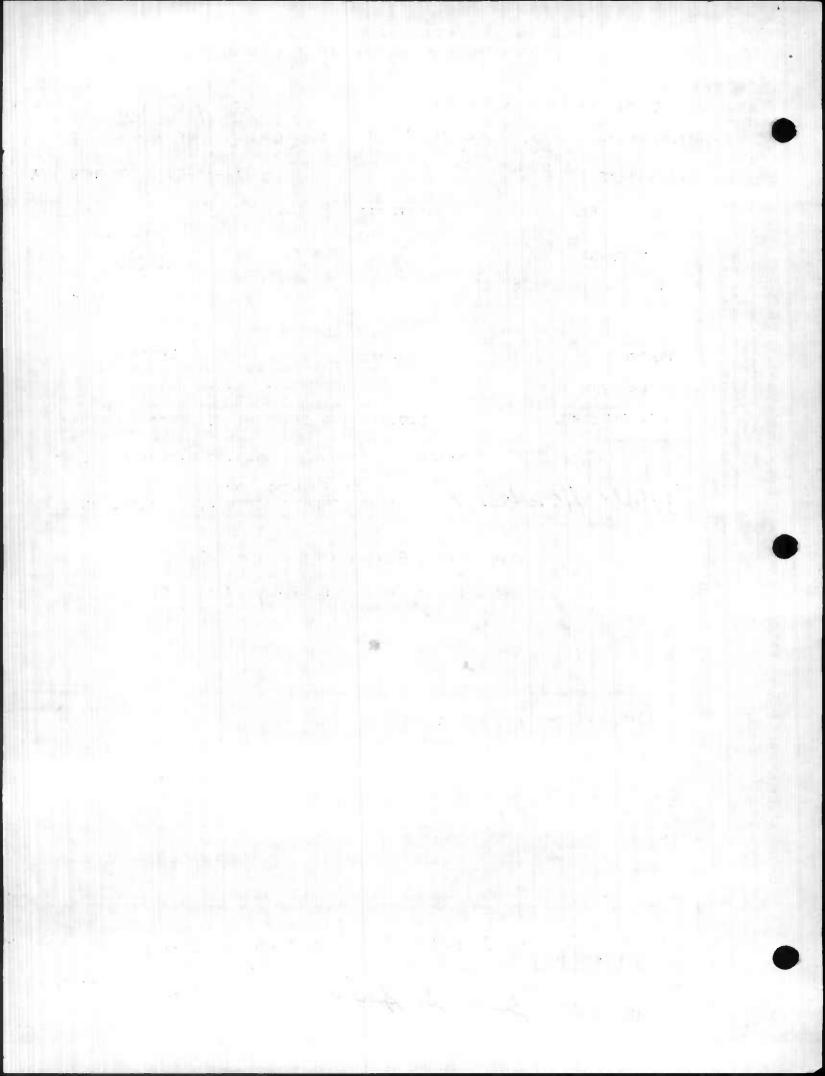
29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST HOSPITAL

32. Registre's Signature.

, RANDALLSTOWN. MO

To the



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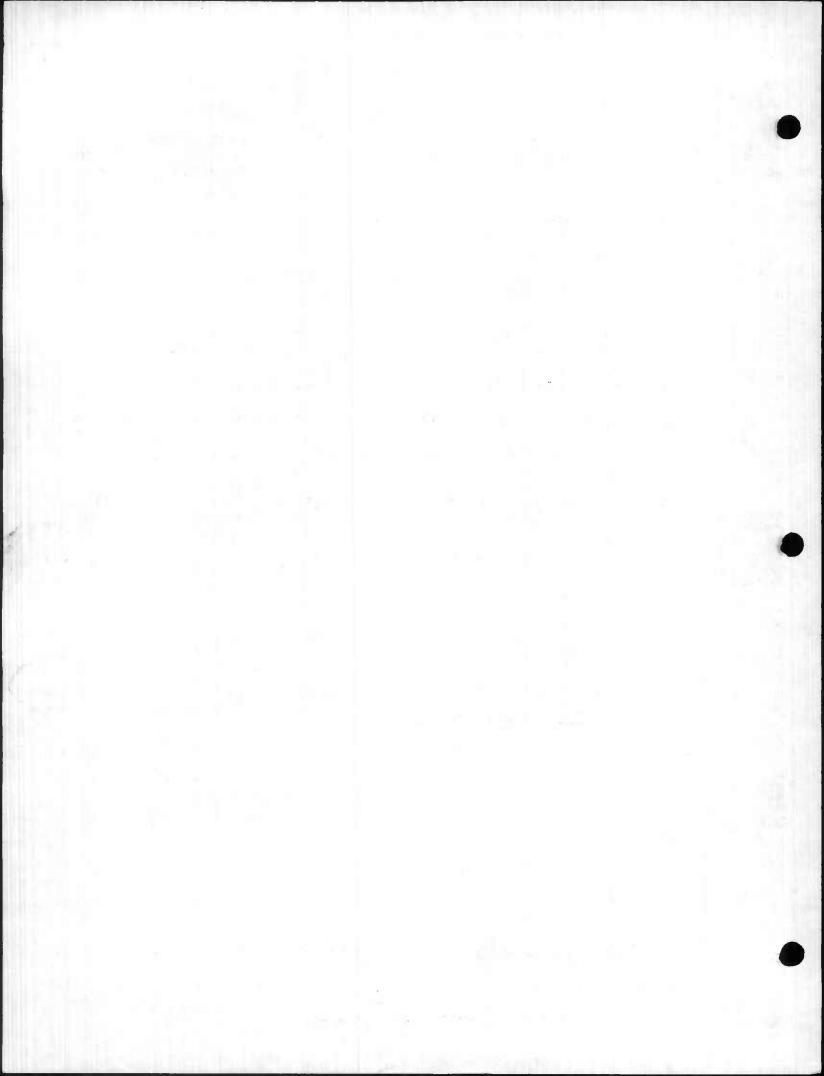
State of Maryland /	Department of	Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Tima of Deeth **Physician** June 27, 1999 Yaer 11:35PM James Sterling Davis /Medical 4e. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Silver Spring Montgomery Holy Cross Hospital H Under 1 Yaar If Under 24 Hrs. 8. Deta of Birth Months Deys Hours Min. 06-09-1793 2 5. Social Security Number 7. Aga (In yrs. lest birthday) 9. Birthpleca (Stata or Foreign **Funeral** Months 1 M 2□ F Pennsylvania 67 190-24-2185 Yrs. Director Usuei Rasidence of Decedent the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at XYes 2 □ No Montgomery Upper Marlboro Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? ò Pages 1 and 2 should be filed within 72 hours after death with 20774 USA 12202 Hunterton Street items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forcas?

1 (X) Yes 2 □ No If Yes, Give Year or Dates: 13. Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indien, Bieck, White, atc. 1 Navar Married 2CM Married Baltimore, Maryland 21215-0020 "natural", or Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Businass/Industry end Mental Hygiene. Eiamantery/Secondery (0-12) College (1-4or 5+) Transportation Metro Manager 17. Fether's Neme (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Marshall Ulysses Davis Mary Susie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Depertment of Health en Important: If Item 27 is any injury or other tras 12202 Hunterton Street, Upper Marlboro, MD 20774 Thelma E. Davis-Wife 20b. Plece of Disposition (Nema of 20a. Method of Disposition Date 20c. Location - City or Town, State Harmony Cemetery 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-2-99 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name end Address of Fecility Latney's Funeral Home W. CC0348 alney 3831 Georgia Ave.NW Wash DC 20011 23a. Part Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or raspiratory arrest, chock, or heart fellure. List only one ceuse on each line. Approximete interval Between **Physician** /Medical immediete Ceuse (Finei . Now Hodokus lymphons disease or condition resulting in deeth) CARS Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Ceusa (Diseese or injury Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical thet initieted events rasulting in deeth Lest the Due to (or as e consequence of): signed by the e Pert ii. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of ceusa of deeth? 24a. Wes an autopsy performed? DISSEMINATED AFRADOZOSIEV page 2 2 NO. 1 ☐ Yas 2 ☐ No certificate Be 25. Was case referred to medical 28. Piece of Deeth (Check only one) Hospitei: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No this funeral (28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 5 Panding investigation 1 Neturel 1 ☐ Yes 2 ☐ No hours after death. 2 Accident Director: 6 Could not be determined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Piece of injury - At home, ferm, straet, factory, office building, atc. (Specify) To the Hospital of within 24 hours a To the Funeral D completely filled in 1 🗹 Cartifying Physician: To the best of my knowledga, daath occurred at the time, dete end pleca, end due to the causa(s) end mennar es stated. 29a. Cartifian Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29b. Signature end the of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 1500 FOREST GIEN RD. SILVER SPEINGUN ZO910 REAGAN MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 9 1999

DHMH 16 Rev 6/95

Registrar



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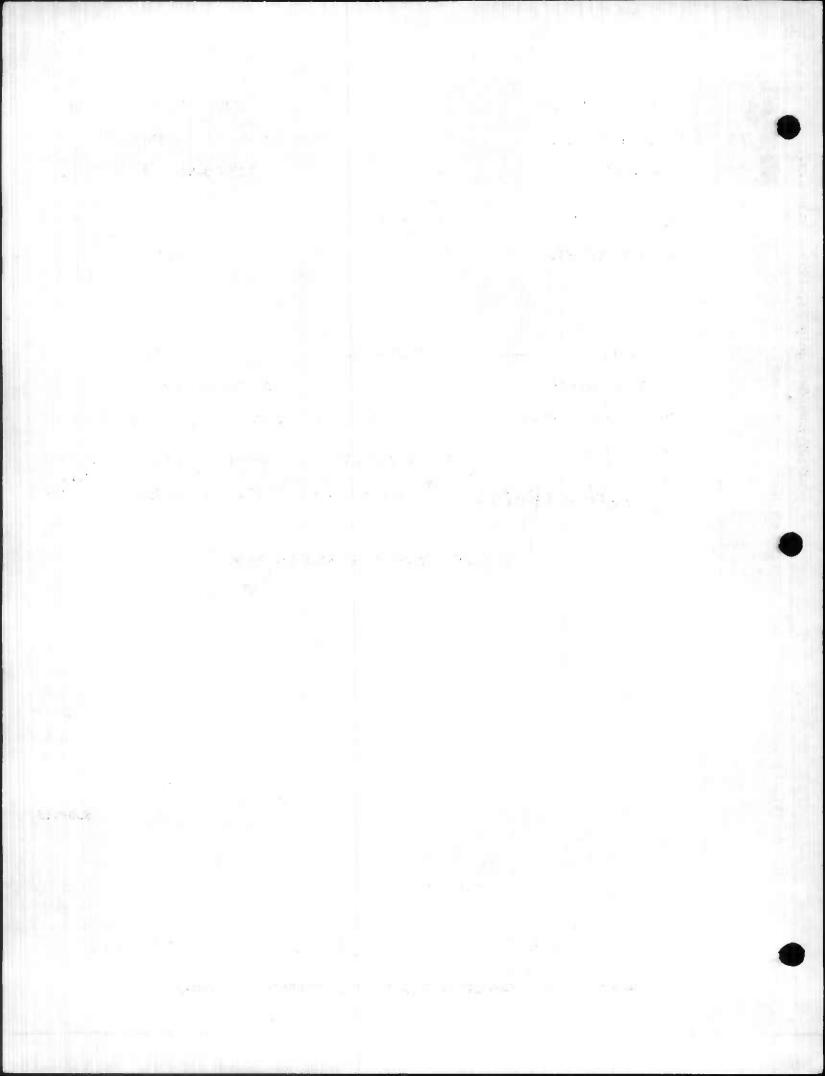
State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 23 1999 ear Month ROBERT LEE EDMONDS 6:50am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS D.V. TIMONIUM BALTIMORE 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. Date of Birth (Month, Dey, Year) 12-30-52 Birthplaca (Steta or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□ F Days Hours 217-56-7569 46 Vrs Director MD. Usuai Residenca of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 → Yas 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 127 S. EXETER ST. 21202 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Give X Yaar or Datas: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) -10-TRASH REMOVAL SANTTATION 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Be HENRY L. EDMONDS EVELYN MAE JOHNSON P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) HENRIETTA WEST(SISTER) 1908 GREENGAGE RD. BALTIMORE, MARYLAND 21244 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 8-2-99 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Sarvice License 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 NO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medicai immediate Cause (Final disease or condition resulting in death) ACQUIRED IMMUNE DEFICIENCY SYNDROME Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 47 Unknown þ 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to complation of causa of death? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Piace of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPCIE Certification: To 1 Yes 2 No 28a. Date of injury (Month, Dey Year) 27. Manner of Deetl 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certific 29c. Licanse number 29d. Date signad (Month, Day, Year) 7/23/99 143725 30. Name and address of person who completed cause of death (item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day Year) TIMONIUM, MD 21093 32. Registrar's Signature souls

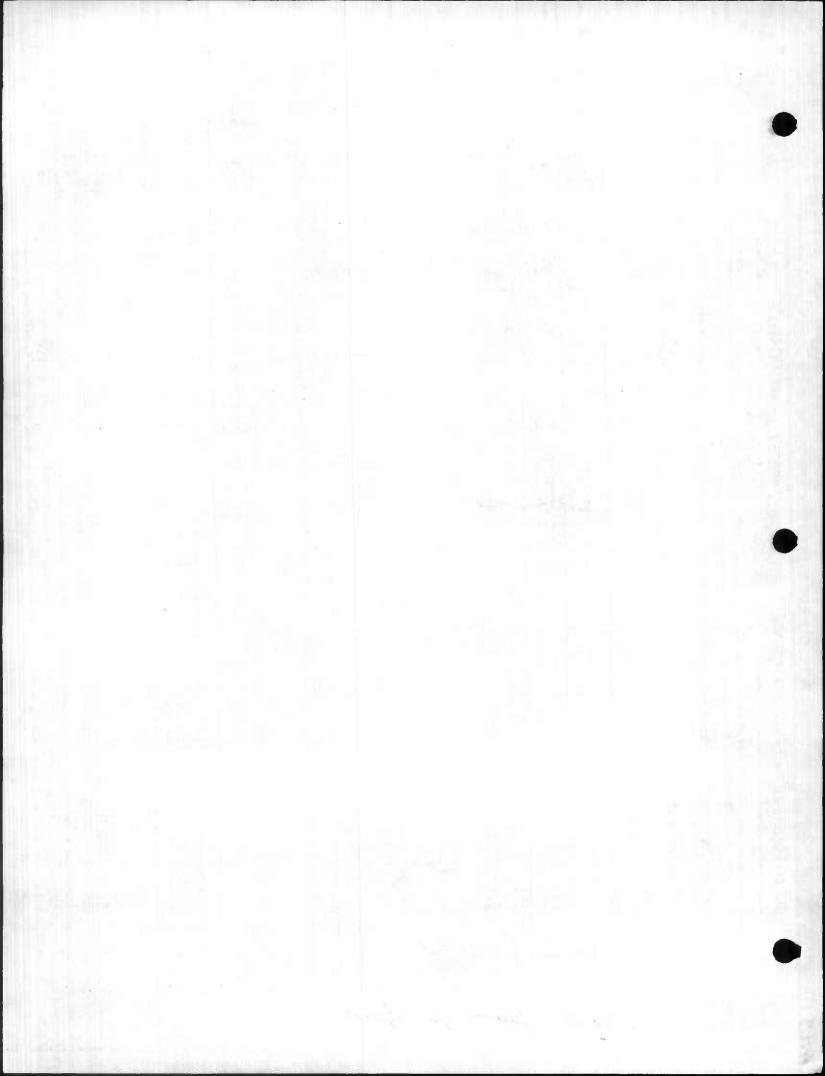
State Registrar

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Z	Mer	2	TOMMIE	1-0	REMAN	IAWA	NDA		OPE	
Ma	d 2 sh th and 7 is m treum		19a. Informant's Name/Relationship (Type, Print) TAWANDA COPER (MOTHS	1 4	lailing Address (Street		41	City or rown, s		
- 01	Health Hem 27 other tr			0b. Place of D	isposition (Name of		Date :	20c. Location - (0. 21216 vn, State
Baltlmore	Pages nent of int: If he iry or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		crematory or other place LVA-RY CE		27-99	BALTI	unor	MADWAL
alth	当年五年		21. Signature of Funeral Service Licensee	71. CA	22 Name and Address	of Facility BR	×/-//	TO TO	TOPE	PINEYCHIL
Ö	Ded in page 1		AN TARL		JOSEPH	A H. KOR	LAVE	BriTI	WERK	Mb. 21217
			23a. Pa 1. Enter the disease, or complications that cause 11 ship k, or heert feiture. List only one cause on each line.	death. Do not	enter the mode of dyir	ng, such as cardiac or	respiratory and	est,	1 1	Approximate Intervel Between
Я	Physician		signal, or neer reliable. East only one cease on each line.	1				0		Onset and Deeth
М	/Medical Examiner		Immediate Cause (Finel disease or condition	to V.	ole St	ab u	OM	ds		
	c xammer ,	-	resulting in deeth)	to (or as a cor	nsequence of):					
	nsit	Examiner	b							
	be executed sician and burial-transit	Xar	if any, leading to immediate	to (or as a cor	sequence of):				i	
58760,	cate be executed physician and ithe burial-fransit	dicai	cause. Enter Underlying Cause (Disease or Injury thet initiated events	to (or as a con	secuence off:					
_		- GD	resulting in death) Last	10 (01 00 0 0 001	ooqualitaa ay.				i	
Box	death certific e stiending p od for use as	and	d							
0.	0 6 2	Physician/M	Part II. Other algnificant conditions contributing to death but no	t resulting in th	ne underlying cause giv	ven in Pert I.	23b. Dld to	bacco usa con	tributa to	the cause of death?
<u>P</u>	d by th						1 🗆 Ya	10 No	3 Prob	ably 4 Unknown
Records,	8 8 8	d by					24a. Wes a	n autoneu	24h Wai	re autopsy lindings
200	been sign should be	etec					perform		con	ilable prior to
Rec	has has	Completed					×	• • • • •	1	eath?
Vital	ician: The li certificate ha rector, page	e Co	25. Was case referred to medical			00 01	120 Ye		JA	Yes 2□ No
5		0 8	axaminer?	2 ER/Outpo	atient 3 DOA Oth	26. Place of Death		14	r (Specify,	SCENE
ot	를 급 등	n: T	27. Menner of Death 28a. Dete of Injury		e of 28c. Injur		-	w injury occurre		SCENE
Division	Attending Ph ir death. ector: After th by the funeral	Certification:	2□ Accident investigation	er) Inju		Yes 2 No	Suhle	at SH	Lat	bed
<u>×</u>	r Atterderrecte	#	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S)	At home, ferm	, street, fectory, office	21	of. Location (St. City or Town	reet and Number, State)	or or Rural	Route Number,
0	thai or rai Dir lied in				NKrou		U	KNO	wn	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my 2/ Medical Examiner: On the basis of examiner stated.	knowledge, d mination and/o	eath occurred at the tir or investigation, in my o	me, date and place, ar opinion, death occurre	d due to the ca d at the time, da	use(s) and mar ate and piece, a	nner as sta ind due to	ited. the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	. 0	29c. Licens	se number	2	9d. Date signed	(Month, D	lay, Year)
			Jan whe	M	001	ME		JULY 21	, 199	39
			30. Name and address of person who completed cause of death	(Item 23a) (Ty						
			V Worken Locket, m	1	11 Penn Str	reet, Balt	imore,	Marylan	d_212	01
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's 3	iignature 4	Sporks					
	Registr	di	JUL 2 9 1999 Sentire	1.	mound					



99-3972-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. cm State of Maryland / Department of Health and Mental Hygiene 9 Brian B. Farber AMEND ITEMS: #23 PART I, II, 27 PER MEO G773 7-30-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Brian B. Farber July 08, 1999 10:45 A.M. /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 509 South Bouldin Street Baltimore 5. Sociei Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Davs Hours Min. Yrs. Director unknown unknown unknown unknown Usual Residence of Decedent the Maryland 10e State 10h Counh 10c. City, Town or Location 10d. Inside City Limits rai', or items 23s or 28s-f shore Examiner must be notified at 1□Yas 2□No unknown Director unknown unknown unknown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With unknown unknown unknown Funeral 12. Wes Decedent Ever in U,S. Armed Forces?unknown 1 □ Yes 2 □ No It Yes, Give Year or Dates: 11. Marital Status Unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after can of Health and Mental Hygiene.

Int. If Itam 27 is marked other than "natural", or flor

Int. or other traumfile avent, the Medical Emerinary or other traumfile avent, the Medical Emerinary. 1 Never Married 2 Merried 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white by 3 ☐ Widowed 4 ☐ Divorced unknown Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) unknown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or c 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Wade, Director Ronald S. State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence ot) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): Box 68760, Physician/Medical Due to (or as a consequence of): 88 USB P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t CIRRHOSIS OF THE LIVER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 2 No certificate of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence expother (Specify) at scene 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how Injury occurred funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28h Time of 28c. Injury at Work? After Division 1 Naturel or Attending 5 Pending 1 Yes 2 No r death. investigation 2 ☐ Accident after death 8 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hox To the Fune completely fi (Check only one) To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier

State Registrar

31. Date tiled (Month, Dey, Year)

JUL 2 9 1999

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

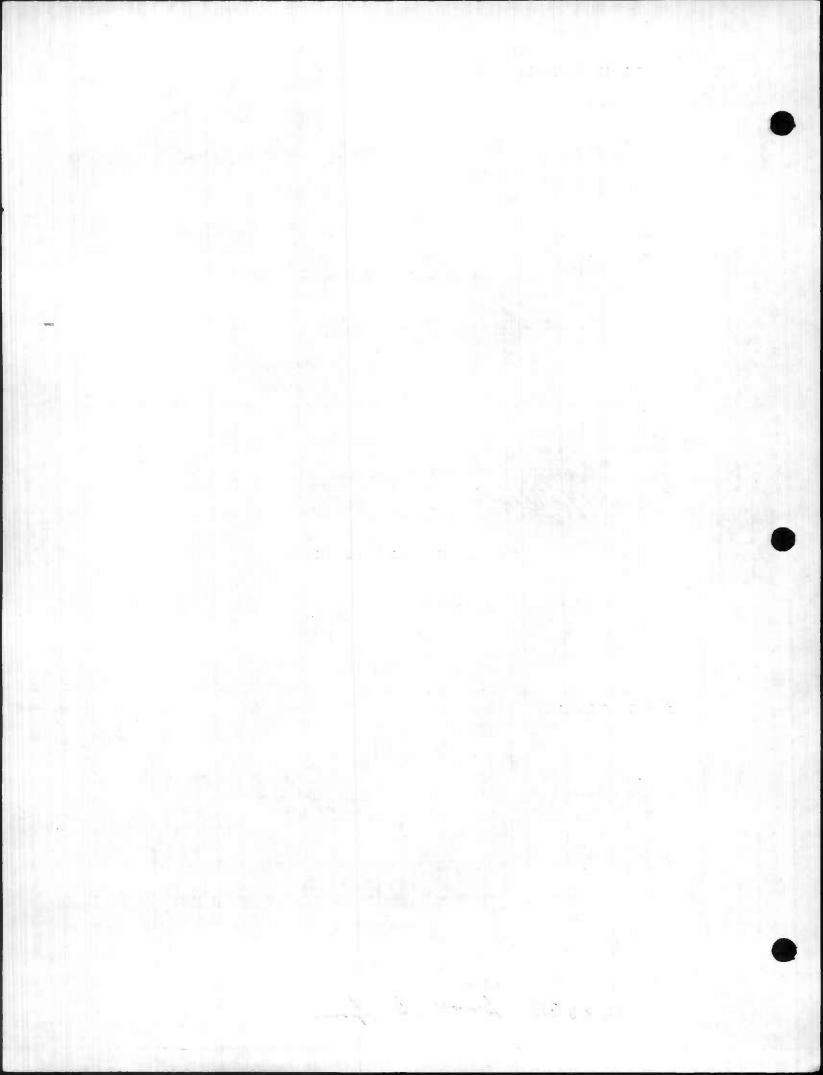
Signature 4

111 Penn Street, Baltimore, Maryland 21201

July 09, 1999

O.C.M.E.

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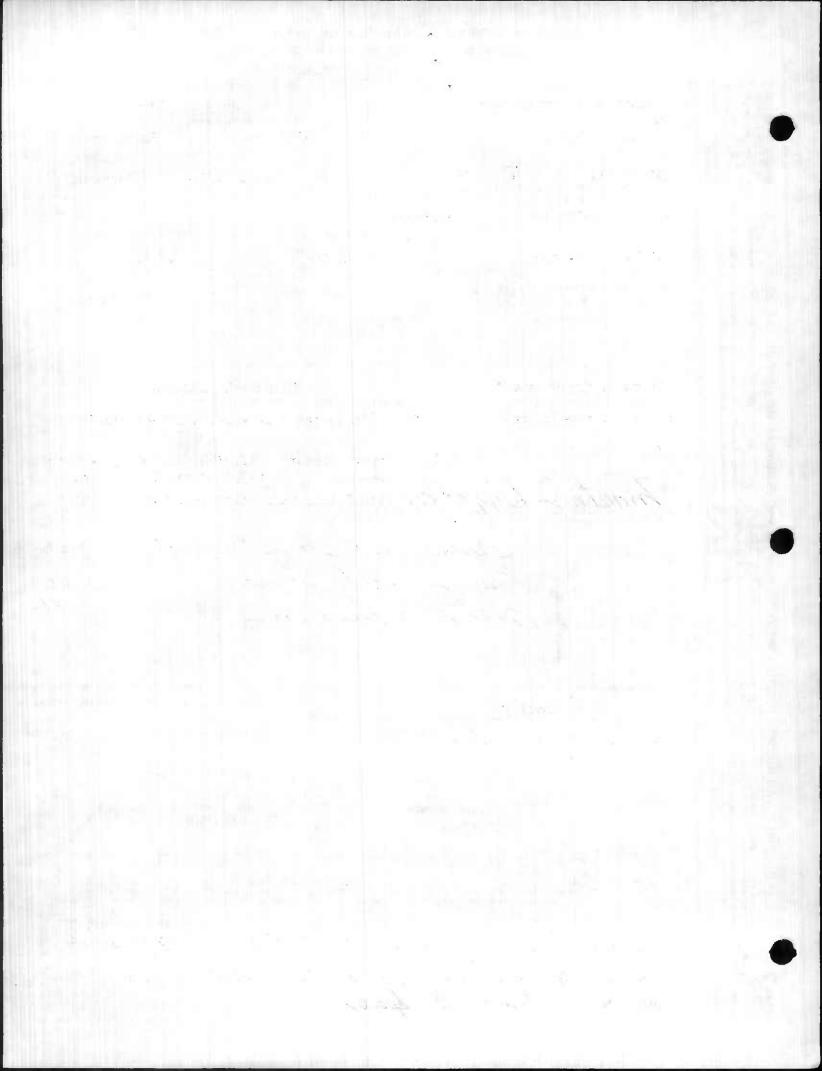
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Catherine E. Freeburger 24, 1999 July 3:00 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22 W. Elm Avenue Baltimore Baltimore If Under 24 Hrs. 5. Social Security Number 6. Date of Birth (Month, Dey, Year) 7. Age (In vrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Min. Months Days Hours 1□ M 2□F Director 219-78-0545 56 10/1/1942 Marvland Usual Residence of Deceden tha Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 7 is marked other than "naturel; or items 23a or 28a-f ahow traumetic event, the Medical Examiner must be notified at 1 ☐ Yes ZCINo MD Director Baltimore Baltimore 10e Street and Number 10f. Zip Code 10a, Citizen of Whet Country? filed within 72 hours after death with 22 W. Elm Avenue S. A. 14. Race - Amarican Indien, Funeral 21206 12. Wss Decedent Ever in U,S.
Armed Forces?
1 Yas 2 No
If Yes, Give X
Yeer or Detes: Was Decedent of Hispento Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 11. Meritel Status Bleck. White, etc. 1 → Never Merried 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) i Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) N/A Never Worked permit. Pagas 1 and 2 should be filed Department of Haalth and Mental Hygi Important: If Item 27 Is marked other eny Injury or other traumatic event, It 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be Albert G. Freeburger Elizabeth R. Spahn 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reietlonship (Type, Print) Albert G. Freeburger 22 W. Elm Avenue Baltimore, Maryland 21206 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete Burial 2 Cremetion 3 Removel from Steta 4 ☐ Donstion 5 ☐ Othar (Specify) Holy Redeemer Cemetery 7/28/99 Baltimore, Maryland 22. Name end Address of Facility Dippel Funeral Home Inc. 21. Signature of Funerel Sarvica Licensea 23a. Pert1. Enter the disease, or complications that caused the grath. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilura. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** DwieBute Immediata Cause (Final disaese or condition resulting in deeth) /Medical **Examiner** Examiner physician and s the burial-transit that the death certificata be axecuted Sequentielly list conditions, if any, laading to immadiete ceuse. Enter Underlying Cause (Diseese or injury that initiated evants resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) attending physical for usa as the signed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Dechotos / Leuleel. 24a. Wes en eutopsy Completed 1 ☐ Yes 2 ☐ No TO Yes 21 No Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this cartific staly filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 esidence 8 Othar (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 5 Pending 1-ENeturel 1 Yes 2 No investigation 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completaly To the Within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D27693 death (Item 23a) (Type, Print) 6530 WALThen Ave Bottimone mcl2 1200 32. Registrer's Signature State

Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dev **Physician** RANK GITTINGS 4c. County of Death JUL /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPITAL SALTIMORE

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) VAMARI 9000 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplace (State or Foreign Country) **Funeral** Deys 1♥ M 2□ F Months 79 Director 213-03-9631 July 27, 1919 Maryland Usual Residence of Deceden the Maryland 10a State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygione. Important: if Item 27 is marked other than "natural", or item 23 or 28s-1 show any injury or other traumatic event, the Medical Energies man in any injury or other traumatic event, the Medical Energies (name) is notified as 10b Count 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3209 Shannon Drive 21213 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Menital Status Bleck, White, etc. 1 Never Merried 2 Married Saitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white Àq 3 Widowed 4 Divorced Completed 16s. Decedent's Uauel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 Tavern Owner Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Clinton Thomas Gittings Mrytle Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn A. Gittings/spouse 3209 Shannon Drive, Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Ronald S Wade Director State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MD 21201

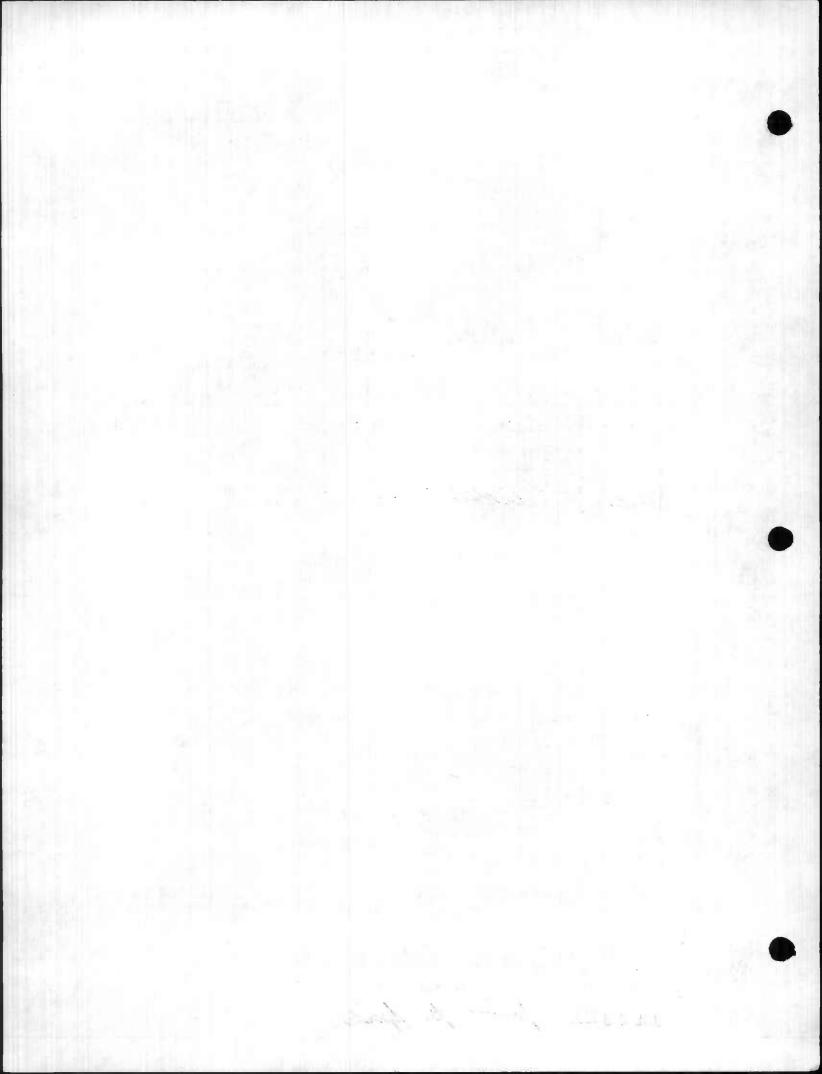
and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel L YMPHOM disease or condition resulting in death) Examiner Examiner attending physician and for use as the burial-transit certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown SCLEROTIC CARDIOVASCULAR DISEASE by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 202 No 1 Yes 2010 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 28a. Date of fnjury (Month, Day Year) 27 Mannar of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 (Natural 5 Pending investigation r death. 1 Yes 2 No To the Hospital or Attend within 24 hours after death To the Funeral Director: / 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause oldeath (Item 23a) (Type, Print) SAMUEL FRIMPONG GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLUD MOZIZZZ 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

2.9 1999

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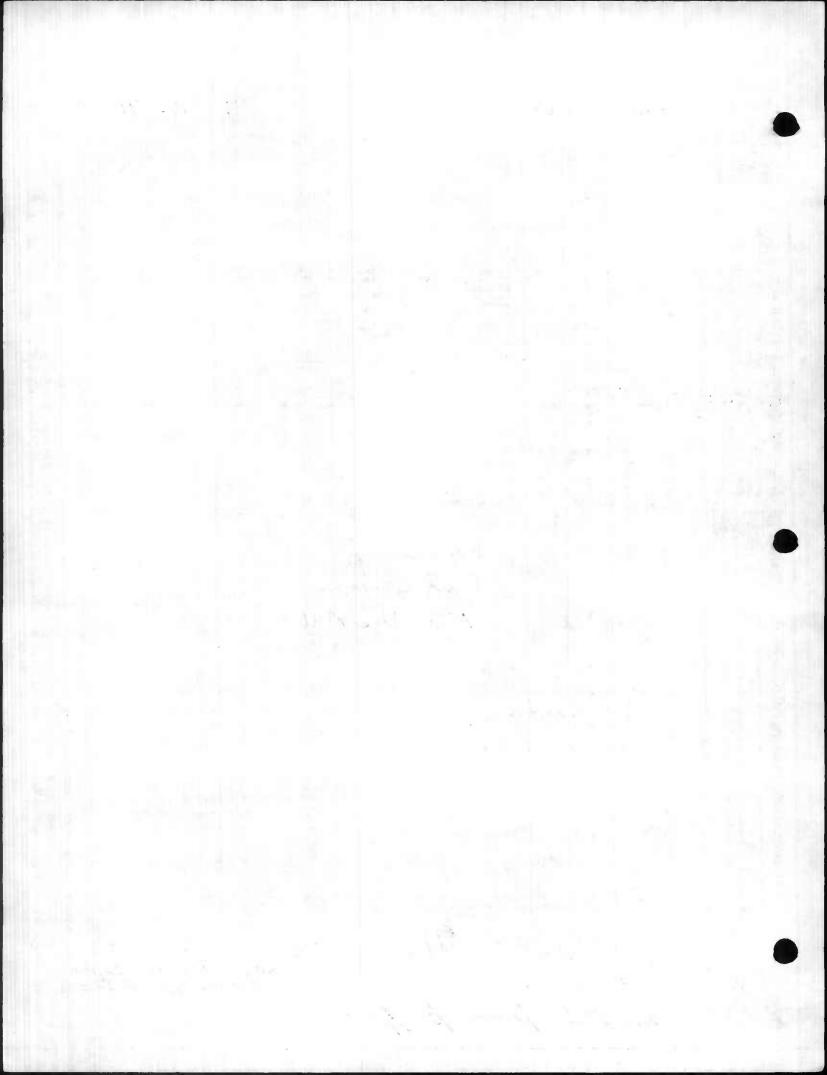


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State of Maryland / Department of Health and Mental Hygiene 99 23883

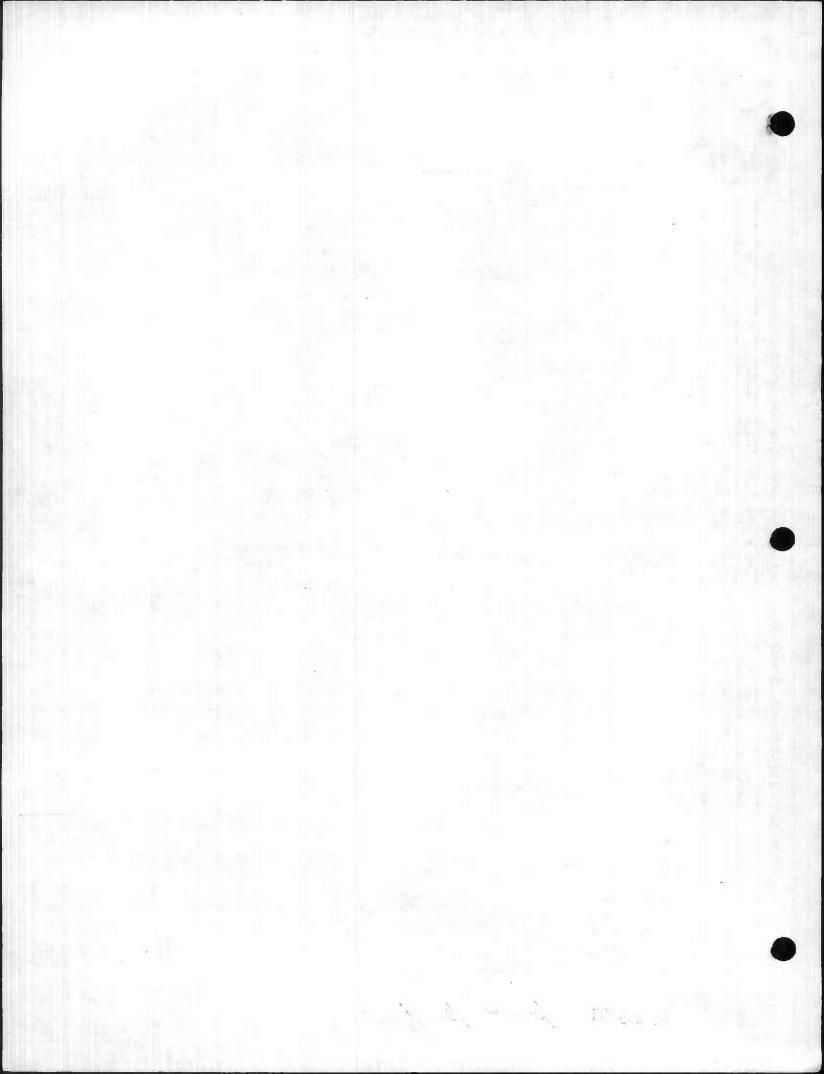
				.y.c.i.c.	Certificate of			Reg. No.	23	000	
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	Tima of Death	
	/Medic Examin		48 Facility Name (if not institution, give street and number)	lica /3/		lb. City, Town, or L	ocation of Death		99 of Death	19.00	
	Funeral Director		5. Social Security Number 6. Sex 7. Age 101 M 2□ F	(In yrs. last birt	7 -111 - 111	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da March	th y, Year) 3, 1954	9. Birthplace (State or Foreign Country) unknown		
	P E		Usual Residence of Decedent 10a. Stata 10b. County	10c. City, Town	n or Location				t0d, 1	Inside City Limits	
	h the Merylan r 28a-f ehow	tor	Maryland	Baltin	more				1	TX Yes 2 No	
	7 28 200	Director	10e. Street and Number	502021	10f. Zip Code			10g. Citizen of \	What Country?		
	23a or		824 N. Bentalou Street	1	unknown						
020	or Norma	by Funeral	11. Marital Status unknown 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent E Armed Forces? t 1 Yea 2 N If Yes, Give Year or Dates:	ınknown	13. Wes Decedent of H If Yes, specify Cube 1 Yes 2 No unknown		pecify Yes or No Rican, etc.)	Specify	ce - American Ir ck, Whita, atc.	,	
21215-0020	within then	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	+)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of work I)	sing		Sb. Kind of Business/Industry		
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rian	0200	To Be	unknown			unknown					
altimore, Maryland	1 and 2 should Health and Men Pm 27 is marke ther traumatic		19a. Informant's Neme/Relationship (Type, Print) unknown	196.	Mailing Address (Street unknown	and Number or Ru	ral Route Numbe	er, City or Town,	Stete, Zip Coo	10)	
			20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 ☑ Other (Specify) in state	20b. Place of cemeters	Disposition (Name of y, cremetory or other plea	e)	Date	20c. Location -	City or Town,	State	
Bait	permit. Pages Department of Important: If its any injury or o		21. Signature of Fun I Service Licensee Ronald S, Wade, D	rector	22. Name and Address State Anat Baltimore,	ony Boar		W. Balti	imore S	treet	
	Physician /Medical Examiner	Iner	23a. Part 1. Enter the disease, or complications that caused in or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death)	Xocth	consequence of):	g, such as certilac	or respiratory a	rrest,	Inte	proximata ervsl Between set and Death	
	tificeta be ng physicia es the bur	Medical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	End	consequence of):	1Ds			1		
	the eff	Physician/W	Part II. Other significant conditions contributing to death but	not resulting In	the underlying ceuse give	en in Pert I.	23b. Did tobacco use contribute to the cause of deati				
P.0	that the death cer ned by the ettendir detached for use		delydeatur				10	Yes 2□ No	3 Probabl	ly MUnknown	
Records,	law requires thet se been signed to 2 should be det	Completed by	wal aufytin	1				an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?		
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Vital	Phyalcien: rthis certific ral director,	Be .	25. Was case referred to medical examiner? Hospital:		trationt 20 DOA Oth	26. Place of Dea					
o	To the Hospital or Attending Physicials within 24 hours effect destinated by the Funeral Director. After this completaly filled in by the funeral di	ation: To	27. Manoer of Death 1 Date of Injustion 2 Accident 2 Accident		ima of 28c. trijun	4 LI NUISING P		dence 8 Oth			
Division	ttal or Att	Certification:	4 ☐ Hornicide building, etc.	y - At home, fer (Specify)	rm, street, fectory, office		28f. Location (: City or To	Street and Numb vn, State)	per or Rural Ro	iute Number,	
	Hosp 24 ho Fune staly fi	edical	29a. Certifier Certifying Physician: To the best of (Check only one) Check only one) Check only one) Check only one) Check only one one one one one one one one one one	examination end	, deeth occurred at the tin d/or investigetion, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and mo date end place,	anner as stated and due to tha	d. I cause(s)	
	To the Hospital of within 24 hours of To the Funeral Di completaly filled is	M	29b. Signature and title of certifier	6. N	29c. License	e number		29d. Date signe	d (Month, Day,	Year)	
			> Jan & / anu	MD	. 1)2	8260		7/10	199		
	OR		30. Name and address of person who completed ceuse of de	ath (Item 23a) (Type, Print)	universit 22 S- 1	3 of h	ND . E	212,	01	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registral	's Signature	1					,	

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4. Se, Social Security Number Social Security Number Social Security Se	25 99 1:30 A
Social Secrity Number S. Sex 10 Months 10 Mont	4c. County of Death
Security Security	BALTMORE
10a. Steta 10b. County 10c. City, Town or Location 10d. City Code	9. Birthplace (State or Fore
12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Was, specify Cuban, Maxican, Puerfo Rican, etc.) 1 Neviral Married 2 Married 2 Married 2 Married 3 Midowed 4 Copyrored 2 Married 2 Married 3 Midowed 4 Copyrored 2 Married 2 Married 3 Midowed 4 Copyrored 2 Married 2 Married 3 Midowed 4 Copyrored 2 Married 2 Married 3 Midowed 4 Copyrored 2 Marrie	10d. Inside City Lim
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Security Security	J.S.A.
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Elemantary/Secondary (0-12) Collegé (1-4or 5+) House Work	. Kind of Business/Industry
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25. Was case referred to medical examiner? 1 Yes	2 No 3 Probably Unkn
25. Was case referred to medical examiner? 1	utopsy 24b. Were autopsy finding available prior to
25. Was case referred to medical examiner? 1 Yes ANNO 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence	completion of cause of death?
25. Was case referred to medical examiner? 1 Yes Park No 26. Place of Death (Check only one) 1 Death (Check only one) 1 Don't 4 Nursing Home 5 Residence	1 Yes A No
5 27 Mannar of Doubh 29a Date of Injury 29b Time of 29a Injury at 29d Decembe how in	
2 Accident Invastigation	6 □Other (Specify)
28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)	
The Continue of Co	t and Number or Rural Route Number, tate)
29a. Certiflier (Check only one) 29a. C	
29c. License number 29d. D	Date signed (Month, Day, Year)
D45700	7/78/99
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)	1001
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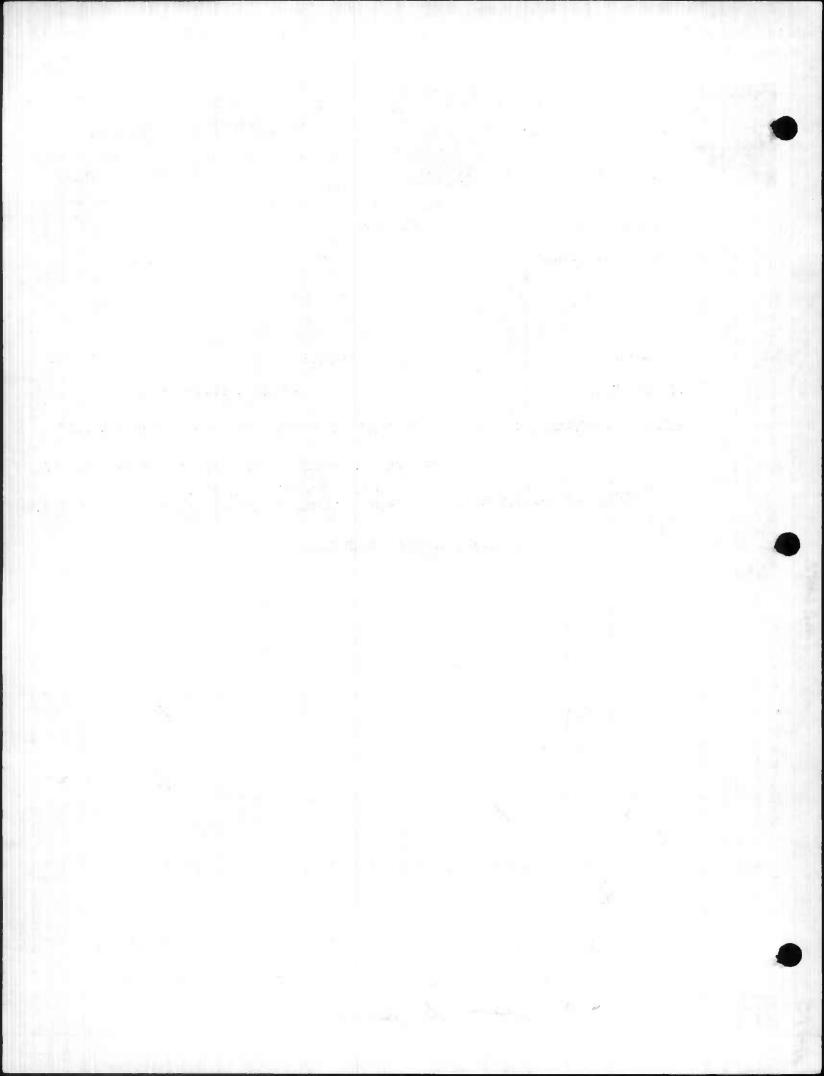


State of Maryland / Department of Health and Mental Hygiene 99 23885

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	or its	by Funeral Director	1 Navar Married 2	**	Armed F	orcas? 2 No iva	If Yas, specify Cuban, Maxican, Puarto						Speci	ick, Whita,	atc.	
5-0	"natural",	etec	15. C (Specify on	ecedant's E	ducation ada complatad))	16a. l	Decedan (Giva kin	nt's Usual Occ	upation	ost of work	rina	16b. Kind of E	Businass/In	dustry	
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	should be fill and Mentel H marked off	To Be	17. Father's Nama (First, GEORGE HERO	LD						A	NNIE	I. HUT	TENBERG	faiden Su <i>ma</i> me) ENBERGER		
	2 sho		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 1111 TAM A HOLMES (HICRAND) 2015 DAMSAY CEREET BALTEMORE MADVIL													
	permit. Peges 1 end 2 Department of Heelth Important: if item 27 i any injury or other tri once.		WILLIAM A. HOLMES (HUSBAND) 2015 RAMSAY STREET - 20a. Method of Disposition (Nama of													
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tim	permit. Peg Department Important: if any injury o		1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LOUDON PARK CEMETERY 7/28/99 BALTIMORE,												MARYI	AND
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1	/Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in daath)													
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			20 Name and address of				Man 00:1 0				_		-		•	
			30. Name and address of FRANCIS KI	HOO 4	M. D	76Ø1	OSLE	ER I	RIVE	TOWS	ON,	MARYL	AND 21	204		
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DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#24a,27&29c PER DR. G773 7-29-99 J.A. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month Hart **Physician** Charlotte July 7:55 AM /Medical 4a Fecility Neme (If not institution, give street and number)

Laurel Regional 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hospital Prince George's Laurel If Under 1 Yeer | if Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Months 1 ☐ M 2 🔀 F 70 579-36-3973 Director June 3, 1929 Usuel Residence of Decadent Pages 1 and 2 should be filed within 72 hours efter death with the Meryland nent of Health end Mental Hygiene and of Health end Mental Hygiene and if them 27 is marked other than "natural", or items 23s or 28s-f ahow any or other traumatic event, are Nedical Examinal must be not need as 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Directo Maryland Prince Georges Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14042 Vista Dr. #110B 20707 U.S.A. Funeral 14. Rece - American indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: white à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 Own home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Alvin Feinsilber Helen Notes 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 935 5th Street, Laurel, MD Roselee Sprindler 20707 20b. Plece of Disposition (Neme of cometery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donetion 5 🛛 Other (Specify) in-state 21. Signeture of Funerel Service Licensee 22. Neme and Address of Fecility Wade, Directo Ronald S Director State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. could d 21201 Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ane Examiner Due to (or es e consequence of): -Examiner Mora physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es a cons uence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 65 attending p signed by the a d be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 28XNo 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel exemiger? Be 26. Piece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Impatient 2 ER/Outpatient 3 DOA

certificate has b director, page 2 s funeral

or Attending Physician: after death. Director: After this certifica Certification: To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th Medical

27. Menner of Death

1 Neturel

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signeture end title of cartifier

5 Pending investigation

6 Could not be determined

State Registrar

1 Vertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) end menner stated.

29c. License number

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Dey, Year)

28c. Injury at Work?

D28759

28f. Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

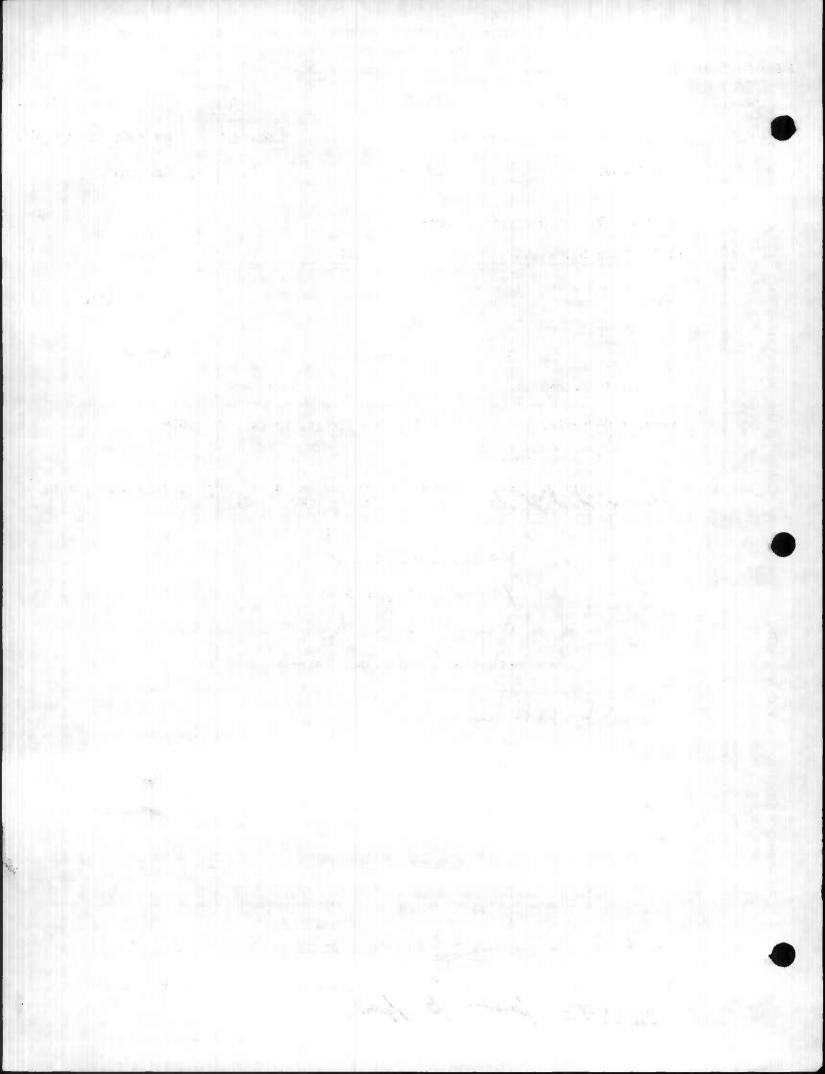
30. Name end eddless of person who completed cause of death (Dem 23a) (Type, Print)

7371 Hawver monder mo 31. Date filed (Month, Dey, Year) 32. Registrer's Signature 2 9 1999

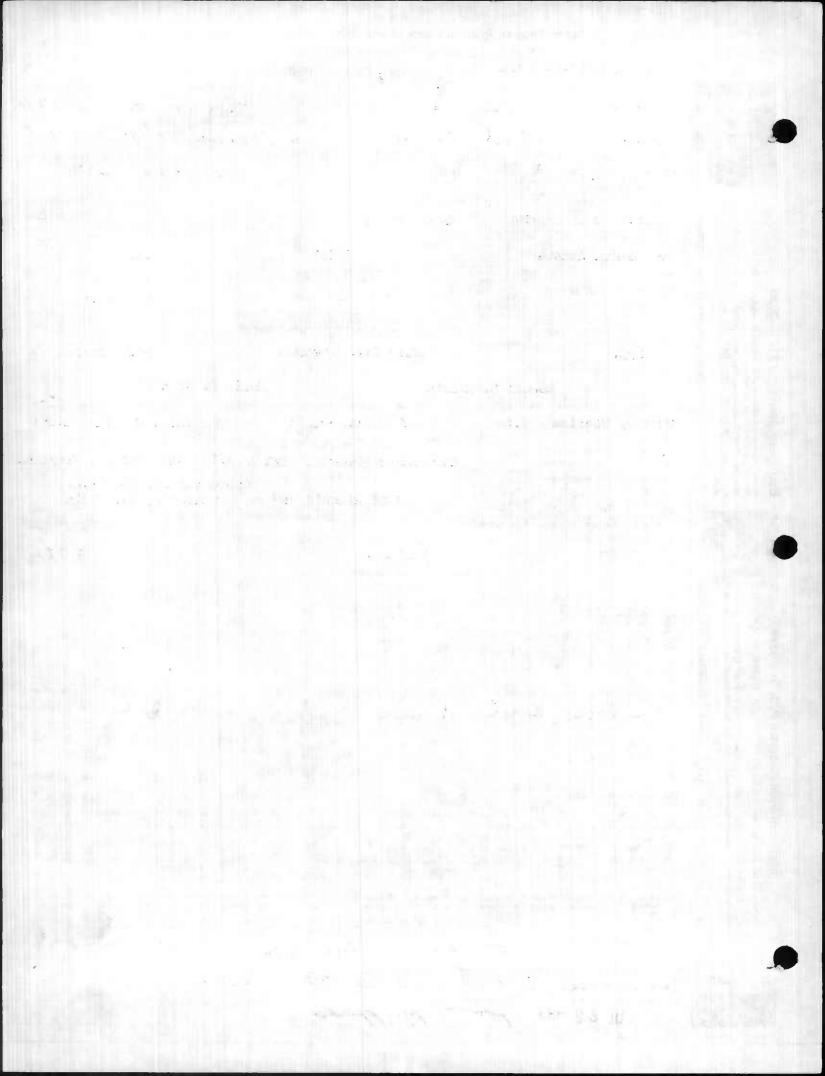
28a. Dete of Injury (Month, Day Year)

28b. Time of

28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify)



	AMEND #24	4a&27 PER MD. G773 7-29	-99 J.A.	Certi	ficate of	Death		Reg. No.	line				
П	Physician	1. Decedent's Neme (First, Middle, La	SI) Narr	ż			2. Dete of De Month	Dev	Yeer	3. Time of Deeth 4:27 / 1			
i.	· /Medical Examiner	4e Facility Neme (If not institution, giv	re street and number)	ie ofer		4b. City, Town, or Ball	Location of Death	-		-e (, if			
	Funeral Director	211-75-3334	Sex 7. Age (In yr	J. 1001 D. 1.100)/	If Under 1 Year Months Deys		(Month, De	h y, Year) - 19 1749	9. Birthple Countr	ece (State or Foreign MD			
	tand	Usuel Residence of Decedent 10e. Stete 10b. County	10c. 0	City, Town or Loca	tion				10	d. Inside City Limits			
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	th with the 23a or 28. It he not	10e. Street and Number 703 Winton Avenu	ıe		10f. Zip Code 210	61		10g. Citizen of V U•S		ry?			
Maryland 2	is 1 and 2 should be filed within 72 hours after death with the Meryland if Health and Mentel Hygiena. If Health and Mentel Hygiena. Other traumatic avent, the Medical Examiner must be notified at other traumatic avent, the Medical Examiner must be notified at To Be Completed by Funeral Director.	11. Meritei Stetus 1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		es Decedent of es, specify Cul	Hispanic Origin? (Spen, Mexicen, Puer Specify:	pecify Yes or No to Rican, etc.)	Specify	in Indien, etc. ite				
	ed within 72 hos ygiena. Ner than "natura ft, me Medical E	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16e. Deceder (Give kir	nt's Usuel Occu	pation during most of wo	rking	16b. Kind of Bu	usiness/Indu	ustry			
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	2 should end Men is marke sumatic	19e. Interment's Neme/Reletionship (Address (Stree	et end Number or R	urel Route Numb	er, City or Town,	State, Zip (Code)			
	1 and 2 Health e hm 27 is ther tra	Shirley Harris	/ wife	703 Wi	inton A	venue	Glen Bu	arnie, M	aryla	and 21061			
Baltimore,	0 0 - 7	20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	Bemovel from State	Plece of Disposit cometery, creme len Haver	tory or other pl		7/21/99	20c. Location -					
Balti	pemit. Peg Department Important: i any injury o	21. Signal of of Funerel Service Licensee 22. Name and Address of Fecility Gonce Funeral Home 4001 Ritchie Highway Baltimore, Md.											
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=	ysician; The list certificate hadirector, page						10	Yes 2210	10	Yes 2□ No			
Vital	certificate rector, pag	25. Was case referred to medical examiner?	Hospital:		10		ath (Check only o	one)					
0	돈 등 등	1 ☐ Yes 2 ☑ No 27. Manner of Deeth 1 ☑ Neturel 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inj		dome 5 Resi	dence 8 Oth how injury occur)			
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 1	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined) 165 2010	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)									
	he Hospita in 24 hours he Funeral pletaly fille edical C		nysician: To the best of my k niner: On the basis of exemi end menner steted.										
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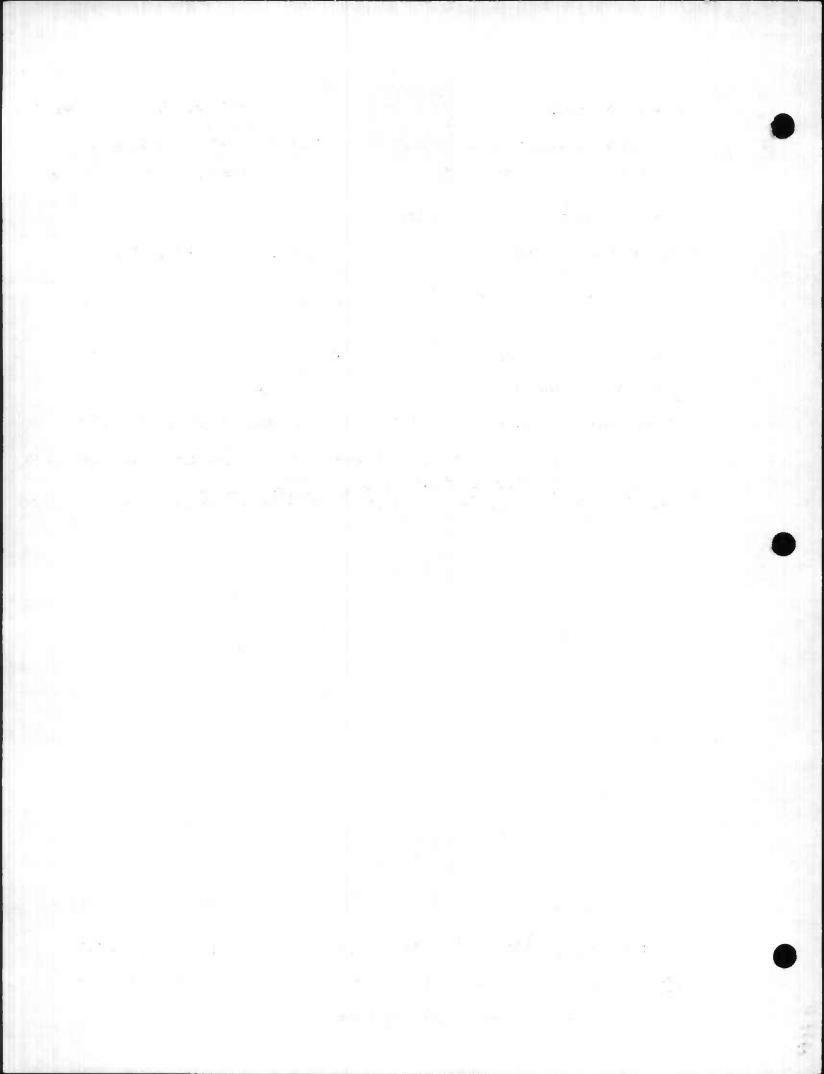
Certificate of Death

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	Physici /Medic		1. Decedent's Nem										2. Date of D Month JULY 2	8, 1999	9 Year		ma of Death 9:00a1	
	Examir		4n Facility Name (Mant Institution of the standard of the City Town and I										ocation of Dec	eth 4c. Co	unty of Death	1		
			Nation	al Inst	titute	s of	Hea1	th			Beth	esda	, MD	Montgomery				
	Funeral		5. Social Security		Sex		(In yrs. last birt			r 1 Yeer	If Under	r 24 Hrs.	8. Dete of B	lirth	9. Birth		tate or Foreign	
	Director		186-38-6		1□ M 20 F		49	Yrs.	Months	Deys	Hours	Min.	Novembe	linth Day, Year) Pr 1, 194	19 Con	intry)	PA	
	and w		Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location													10d. Ins	ide City Limits	
	se Mary	ctor	NC	Wake			Rale	igh									Yes 2□No	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow he Medical Examiner must be notified at	Funeral Director	10e. Street end Nu 5324 Wil		Lane				10f. Ziş	Code	276	13		United	of What Con			
	dea	ner	11. Merital Status		12. Wes Dec	cedent Ev	ver In U,S.	13. W	es Dece	dent of I	Hispanic O	rlgin? (Sp	ecify Yes or N Rican, etc.)	lo- 14.	Rece - Amer		en,	
0	after or its	E	1 🗆 Never Men	ied 2 Merried		2 € No							rican, etc.,			Black, Whita, atc.		
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	filed with Hygiene. Ither than ant, the	NO.	12th Gr		4 Year				tea	che	r			on				
bu	offied other vant, if	Be	17. Father's Name	(First, Middle, Las	st)	18. M						er's Nem	e (First, Middl	le, Maiden Sui	neme)			
/lai	Aenti Aenti riced tice	To	Willia	m T	aylor							Agne	es 1	M. F	alus	zak		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mertal Hygiene. If Health and Mertal Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic avant, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (<i>Type, Print</i>) Edward Hines / Husband 19b. Melling Address (<i>Street</i> end <i>Number or R</i> 5324 Willow Cry Lane													(ip Code) 7613		
re,	is 1 and 2 of Health Hem 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of											20c. Locat	lon - City or 1	Town, Str	ate	
Baltimore,	t. Page rtment o rtant: If njury or		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Slippery Rock Cemetery July 31, 1999 21. Signeture of Eunerel Service Licensee Victor P. Doda, Jr. 22. Neme and Address of Facility															
Bal	Depar Impor any in		21. Signeture of Fr	inerei Service Lice	ensee Victo	r P	Doda, Jr.	Cn	arle	s L	. Ste	vens		al Home			4 21220	
	_		23a. Pert1. Enter the disease, or complications that caused the feeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, hock, or heart fellure. List only one cause on each line. Approximate interval Between															
	Physician	ii i	snock, or nee	nt fellure. List onl	y one cause on	eech iine									i		ai Between end Deeth	
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68760,	e be rsicie		Cause (Disease or injury that initiated events consequence of):															
99	ficat phy as th	Physician/Medical	resulting In death)	Last		00	ue to (or es e c	onsequ	ence or).						1			
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m	the atte	cia	D	II									23b. Did tobacco use contribute to the cause of deat					
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3ec	has law	du													0	of death?		
=	- 4	S											10	Yes XX	10 1	☐ Yes	MNO NO	
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of \	D 10	P	1 ☐ Yes 🏋	40	Hospital:	Inpatient	2 ER/Out	patient	3□ D0	OA Otl	her: 4□ N	ursing Ho	me 5 Re	sidence 6 🗆	Other (Spec	:lfy)		
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Division	58:0	atic	2 Accident	Investigetion					М	1	Yes 2	No						
N N	after death Director: A in by the f	Ħ	3 ☐ Sulcide 4 ☐ Homicide	8 Could not li	200. 1100	e of Injury	y - At home, fer	m, stre	et, fector	y, office				(Street and Nown, Stete)	umber or Ru	ral Route	Number,	
	s aft of all Distriction	Certification:			, June	airig, oto.	(Opcony)							,,				
	hour meri ly fill		29a. Certifier	yt⊠ Certifying P 2☐ Medical Exa	hysician: To the	e best of	my knowledge,	death	occurred	at the ti	me, date a	nd place,	and due to th	e cause(s) an	d manner as	stated.		
	To the Hospital or Atle within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only one)	∠ Medical Exa	miner: On the b and mar	basis of e nner state	xamination and ed.	vor inve	stigation	, in my o	opinion, de	ath occur	red at the time	e, date and pla	ice, and due	to the ca	use(s)	
	Withi To the	Σ	29b. Signature and	title of certifier	δ A		4.7				se number				igned (Month	Day. Yo	ear)	
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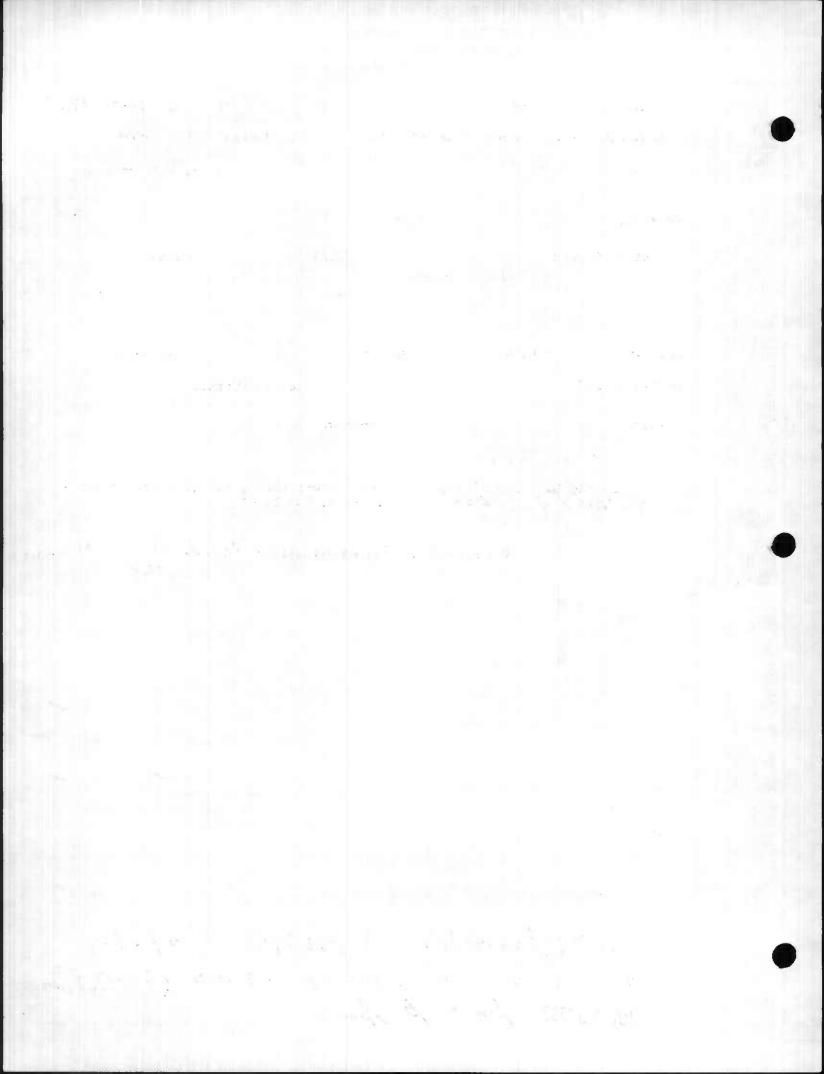
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State of Maryland / Department of Health and Mental Hygiene 99

					$C\epsilon$	ertificate	of L	<i>Death</i>			Reg. No.			
Shows		1. Decedent's Nama (First, Middla, Last)									eth Dey	Yaer	3. Time of Death	
Physic /Medi		Martin Hoi	word							Month 7	6 1	999	1830	
Exami		4a Facility Nama (If not institution, gi			Hospi	ML	4		wn, or Loc	eation of Deetl				
Funeral Director			Sex 7 1⊠M 2□F	. Aga (In yrs. 64	last birthday Yrs.	Months [If Undar Hours	Min	8. Data of Bir (Month, Da July 22	th Year) 1934	9. Birth Cou unkn	placa (Stata or Foreign ntry) OWN	
puel Maria		10a. Steta 10b. County		10c. Ci	ty, Town or I	ocation							10d. Inside City Limits	
Mary	tor	Maryland		Bal	ltimor	е							1 X Yas 2 □ No	
or 28	Director	10e. Street and Number				10f. Zip C	ode				10g. Citizen of	What Cou	ntry?	
23a		208 Bruce Street				2.1	122	3			unknown	1		
Nore, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It litem 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tas 2 If Yas, Giva Yeer or Def	as? unki !□No	i,S. nown	. Was Deceder If Yas, specify 1 ☐ Yas 2 ☐	Cube	spanic Ori n, Maxican Specify:	gin? (Spe i, Puerto F	cify Yes or No Rican, atc.)	Bla	ck, Whita,	- American Indian, k, Whita, atc. - black	
Maryland 21215-0020 d 2 should be filed within 72 hours et th end Mental Hygiene. T'la marked other than "natural", or traumetic event, the Medical Exam	Completed	15. Decedent's E (Specify only highest gr Elemantary/Secondary (0-12) unknown	ducation eda completed) Collega (1- 1nknown	lor 5+)	16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DONOT usa retired) unknown unknown								ndustry	
D PER T	To Be Co	17. Father's Nama (First, Middle, Las.			un un	.KIIOWII_		18. Motha	r's Nama	(First, Middle,	Maiden Sumai			
laryland 212 2 should be filed withi end Mental Hygiene. Is marked other than aurmatic event, the M		Martin Howard						Est	elle	Carte	:			
aryla should and Men	-	19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Tow											p Code)	
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Baltimore, pemit. Pages 1 er Department of Hea important: If item; any injury or other once.		20a. Mathod of Disposition 1 ☐ Burlet 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		ete	Place of Disposition (Nema of cematary, crematory or other s			B)		Data	20c. Location	- City or T	own, State	
Baltimo pemit. Page Department of important: If any injury or		21. Signeture of Furth Sarvice Lice Ranald S		irect	or S	tate And all tate And all tate And altimon	nato	omy B			V. Balti	lmore	Street	
Physician /Medical Examiner	76	Part I. Entar tha disaase or conshock, or haart failura. Ist only Immediata Causa (Final diseasa or condition rasulting in death)	ona causa on aa	ch lina.							er of blude		Approximate Interval Between Onset and Deeth Henon Hes	
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Ord requir	Completed by										an autopsy ormed?	av Cr	Vara autopsy findings vailable prior to ompletion of cause I death?	
The law rate hes b	E O									10	Yas 20 No	1	Yas 2010	
Vital I	Be	25. Was casa raferred to medical axaminar?						26. Place	of Death	(Check only	one)			
of Vita Physician: this certific ral director,	2	1 ☐ Yas 2 ☐ No			ER/Outpati		Othe	4 🗆 Nu	1		dance 6 □Ot		ify)	
E ge age	Certification:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not the	n	Injury Day Year)	28b. Time Injury		. Injun Work	yat ⟨? Yes 2□	No		how injury occu			
Divi	Certifi	3 Suicide 6 Could not to determined	208. PIACE C	f Injury - At h g, atc. <i>(Speci</i> i	oma, farm, s	traat, factory, o	office		2	8f. Location (City or To	Street and Num wn, State)	ber or Flui	ral Route Number,	
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical (29a. Certifier Check only one)	nysician. To the bas miner: On the bas and manne	is of examina	owledge, dea ation and/or i	ith occurred at nvestigation, in	the tim	ie, date an pinion, dea	d place, a th occurre	nd due to the ed at the time,	cause(s) and m date and place	anner as , and due	stated. to the cause(s)	
To th To th comp	M	29b. Signature and title of certifier	Fran	us M	<u>S</u>			23	99		29d. Date sign	6 9	, Day, Year)	
Off		30. Na and addrass of person of the SAWLET J.	mpleted cause	of death (Itan	m 23a) (Type	Deinel				MED	225	GRE	TENE ST	

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 AMEND ITEMS: #4C, 10B, 15, 19A-B, 20A-C 21,22 PER F.H. Certificate of Death 2. Dete of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death **Physician** Bessie Hall /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner Sa Morage renesis Idercare If Undar 24 Birthplace (Steta or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□M 20XF Months Days Hours 215-28-6017 Director 29, 1931 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show once. 10a. State 10b. County 10c. City, Town or Location 10d. tnsida City Limits Yas 2 No NA Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 2706 Reisterstown Road 21215 U.S.A. 14. Rece - American Indian, Biack, White, atc. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yes 2 🔯 No If Yes, Give Yaar or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify black þ 3 NWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) unknown 6TH unknown NA Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Joseph Jones Katie Leopold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) unknown DORIS McCRAY unknown 2706 REISTERTOWN ROAD BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ₺ Burial 2 Cremation 3 Removal from State VOSHELL MEMORIAL GARDENS 8/6/99 DUNDALK, MD 4 □ Donation 5 □ Other (Specify) in state 21. Signature of Funeral Service Licensee WILLIE EDMONDS 22. Nama and Address of Fecility AL-TIMORE MD 21202 W.M. C. MARCH F.H. Made Director Ronald State Anatomy Board, 655 W. Baltimore Street Baltimore, NO 21201 1101 E. NORTH AVE. 23a. Part . Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Hente Mys cardial Examiner Examiner attending physician and for use as the burial-tran Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be exec Box 68760. Physician/Medical Dua to (or as a consequence of): USB as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Munknown Division of Vital Records, P 24b. Were eutopsy findings eveileble prior to 24e. Was en eutopsy performed? Completed completion of cause of death? has 1 Yes 2 QNo 1 ☐ Yas 2 ☐ No 25. Was case reterred to medical exeminer?

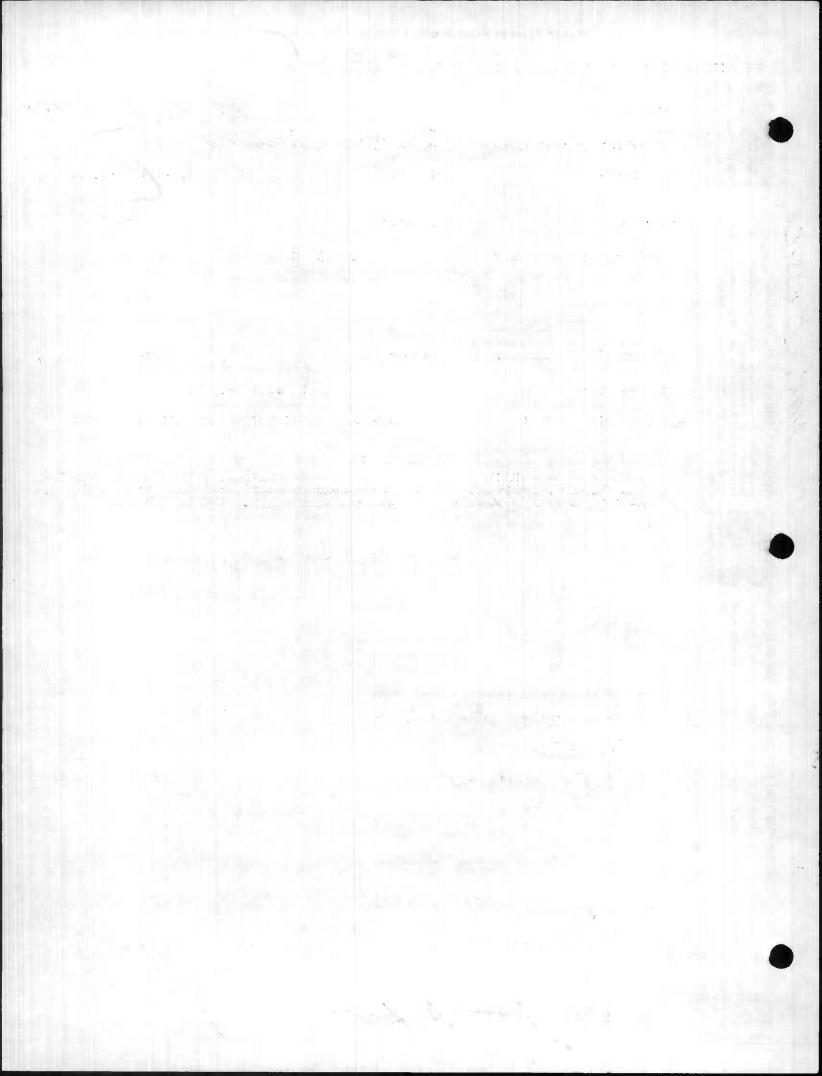
1 Yas 2 No 26. Place of Death (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 M Netural 1 ☐ Yes 2 ☐ No 24 hours efter death. Investigation 2 Accident 6 Could not ba 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) within 2 2 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of partifier D-4054 hly 26, 1999 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) 3350 Wilkes Avenue DR. OCHANES Beltimore, MD 21229 31. Date tiled (Month, Dey, Year) 32. Registrar's Signeture

DHMH 16 Rev 6/95

State

Registrar

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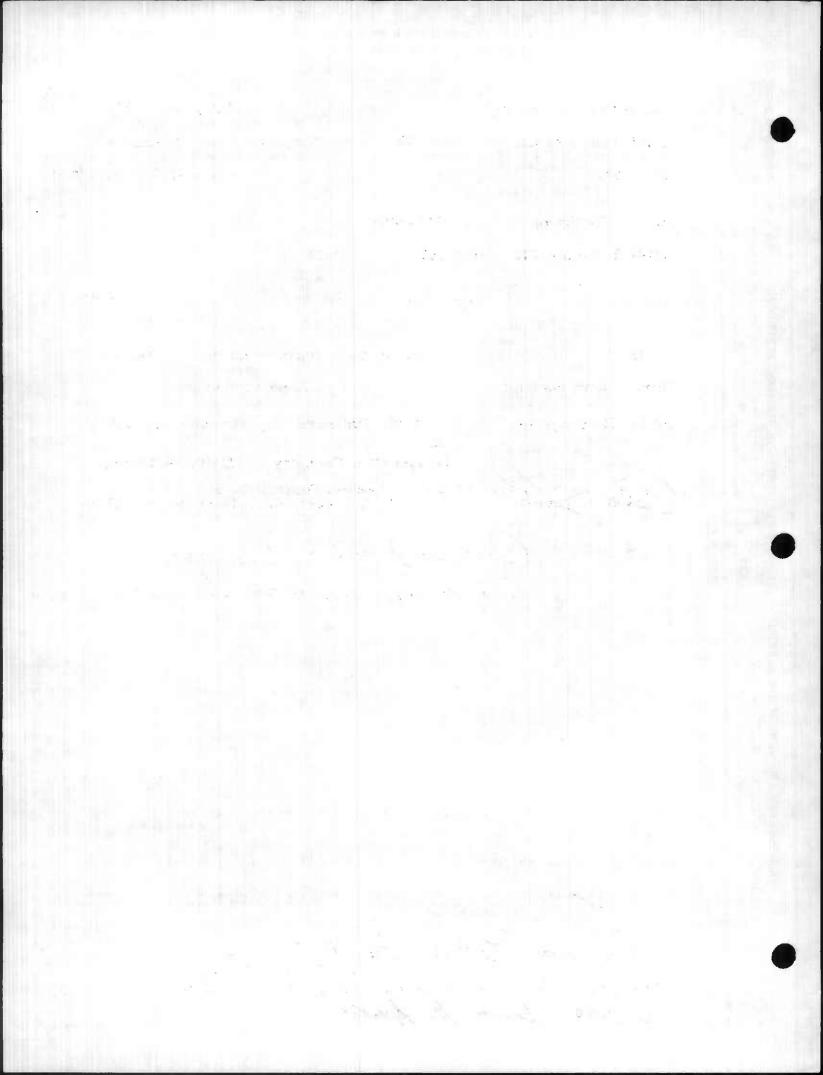
State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Clifford John Hartung /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner **Unit 103** 12101 Tullamore Ct. **Timonium** Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** M 20 F Deys Months Director Dec. 8 1936 Maryland 216-34-2759 Usuai Residence of Deceden the Manyland 10d. Inside City Limits 10c. City. Town or Location 10e State 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examptor must be notified at 1 ☐ Yes 2 No Director Timonium Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12101 Tullamore Ct. Unit 103 21093 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic OrlgIn? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritel Stetus Bleck. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event. 1 X es 2 No If Yes, Give Yeer or Detes: 58 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White Specify: by - 159 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) 12 3 Systems Business Analyst Computer 18. Mothar's Neme (First, Middle, Meiden Sumame) 17. Father's Nama (First, Middle, Last) Be Clifford John Hartung Anna V. Bagdonas 19e. informant's Neme/Raletlonship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Celeine Hartung/wife 12101 Tullamore Ct., Timonium, MD 21093 20e. Mathod of Disposition
1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Pleca of Disposition (Name of competery, cremetory or other place) Dete 20c. Location - City or Town, State 4 Donetion 5 Other (Specify)

21. S ature Vuner ervice Licensee Loudon Park Cemetery 7/31/99 Baltimore, MD 22. Name end Address of Fecility no Lemmon Funeral Home owell M. Delimion 10 W. Padonia Rd., Timonium, MD 21093 Tent1. Enter the discertification, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner Due to (or es e consequence of): physician and s the burial-transit Sequentielly list conditions, if eny, laading to immediate cause. Enter Underlying Ceusa (Diseese or Injury that Initieted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, death certificate be Physician/Medical Due to (or es e consequença of) USB BS signed by the at d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown by 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Wes en eutopsy Completed page 2 has 2 / No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funeral director, 26. Placa of Deeth (Check only one) Be 25. Wes case referred to medical exeminer? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28c. Injury at Work? Certification: 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending invastigation 1 Maturel after death. Director: Aft 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be datermined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office bullding, etc. (Specify) illed in by 4 I Homicide To the Hospital of within 24 hours af To the Funeral D completely filled I 1 Cepitying Physician: To the best of my knowledge, deeth occurred at tha time, date and place, and dua to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier edical 29c. License number 29d. Dete signed (Month. Dev. Year) 29b. Signeture endititle of certifier rango mne 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) DKINE //M 1051 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature State JUL 2 9 1999 Registrar

A48+ DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Edward R. Harrison JR. 1701 19 99 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death R Adams Cowley Shock Trauma Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Months Days Hours 1 X M 2 □ F Yrs 215-25-0172 19 Maryland June 18, 1980 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carrol1 1 ☐ Yes 2 KI No Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 United States 7070 John Pickett Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced Yeer or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own farm Student/ Farm worker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father'a Name (First, Middle, Last) Edward R. Harrison, Sr. Jayne S. Bauer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Parents Mr. and Mrs. Edward R. Harrison, Sr. 7070 John Pickett Road Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Morgan Chapel Ch. Cemetery 7/23 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Licensee Burrier Queen Funeral Directors, P.A. ama B Ow. 1212 W. Old Liberty Road Winfield, MD 21784 Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to or seen failure. List only one cause on early line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Head losed Due to (or as a consequence of) whonan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or es e consequence of): Laceration 23b. Dig tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitel: 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural

Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Box 68760. P.O. ate has been signed by the page 2 should be detached of Vital Records, ģ Be Completed ial or Attending Physician: The safer death.

Si Director: After this certificate ed in by the funeral director, pa Medical Certification: To Division filled in by

Physician

/Medical

Examiner

Funeral

Director

ahow

r than "natural", or items 23a or 28a-f aho the Medical Examinar must be notified at

"natural"

al Hygiene.

. Pages 1 and 2 should be file ment of Health and Mental Hy lant: If Item 27 is marked oth jury or other traumatic event

Department Important: If any Injury or

Physician

/Medical

Examiner

filed within 72 hours after

21215-0020

Baltimore, Maryland

Director

Funeral

þ

Completed

25. Was case referred to medical

2 Accident

4 Homicide

3 Sulcide

29a. Certifier (Check only one) 5 Pending investigation

6 Could not be determined

28a. Date of Injury (Mgnth, Day Year) 14/ 99

M. D.

Injury 0008 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28c. Injury at Work? 1 ☐ Yes 2 ☑ No

Motor Vehicle Crash

28f. Location (Street and Number or Rural Route Number City or Town, State) Rt 27 At Ridgeville 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

046147

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

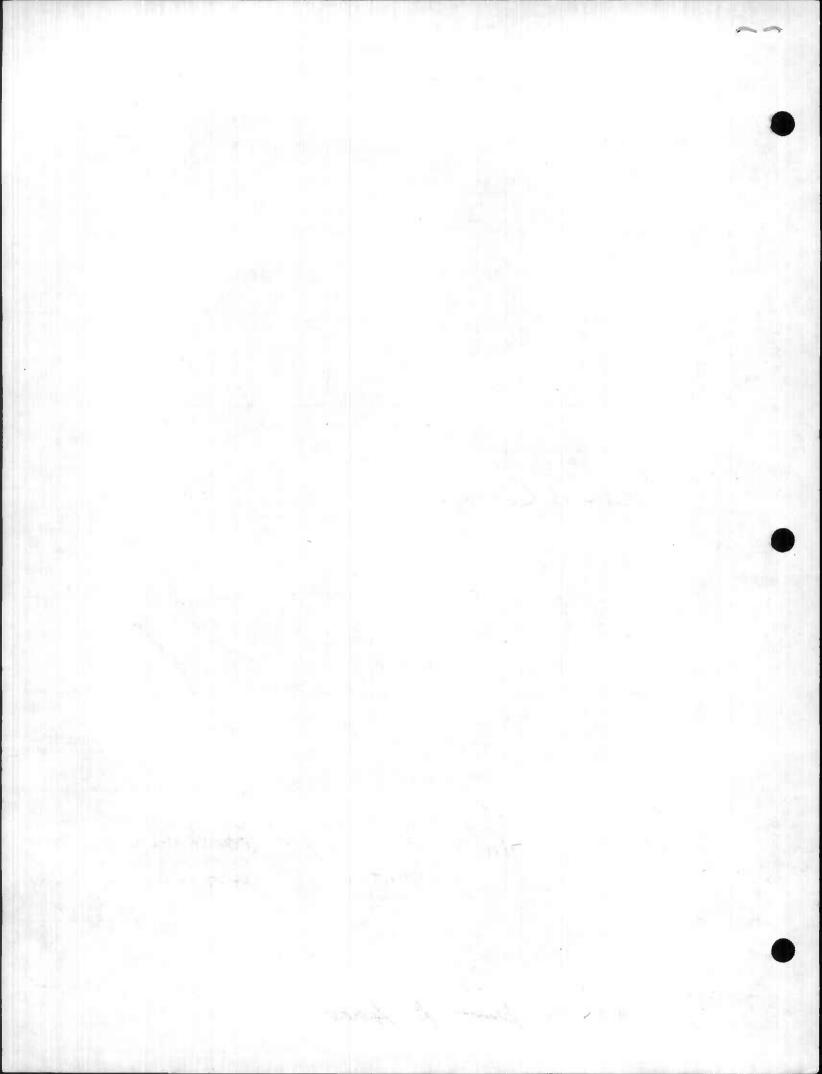
William C. Chiu m.0. R Adams Cossley Shick France Center Saltimore, MD

State Registrar 31. Date filed (Month, Day, Year) JUL 2 9 1999

William C Chin,

32. Registrar's Signature

To the Hospital c within 24 hours at To the Funeral D completely filled i



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Clarence R. Hawkins July 27 1999 7:45 PM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clementine Ct. -Apt 2A Rosedale Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 120 M 2□ F 017-12-2330 Director 84 30 1914 Massachusetts Uaual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow nodfied at Baltimore 1 ☐ Yes 2 No Director MD Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? forma 23a or USA 4 Clementine Ct. - Apt 2A Funeral 21237 12. Wes Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian than "natural", or item the Wasters Exercises Black, White, etc. 1 Never Married 2X Merried 1X Yes 2 □ No 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Beth - Steel Pages 1 and 2 should be filed w timent of Health and Mental Hygier tant: If Nem 27 is marked other th jury or other traumatic avent, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Albert E. Hawkins Ella M. Woodworth 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olive M. Hawkins 4 Clementine Ct. Apt 2A /wife Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Department of Important: If It any Injury or o July 28 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, MD 22. Name end Address of Facility
Connelly Funeral Home of Dundalk 21. Signature of Funeral Service Licenses 5 7110 Sollers Point Rd 21222 Do not enter the mode of dying, such as cardiac or respiretory arrest, 23a. Part 1. Inter the dis-as-, or complications that caused the deal shock, or heart feilule. List only one cause on each line. **Approximete** Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a cons Examiner Duelt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue (or as e consequence of): physician Physician/Medical the Due to (or as a consequence of): 88 188 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 188 **page 2** 1 Yes 2UNO 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Pesidence 8 Other (Specify) 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 5 Pending investigation 1 Tyes 2 □ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide filled in edicai 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mil

the Maryland

filed within 72 hours after death with

21215-0020

Baltimore, Maryland

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital or Attanding Physician:

Hospital

the

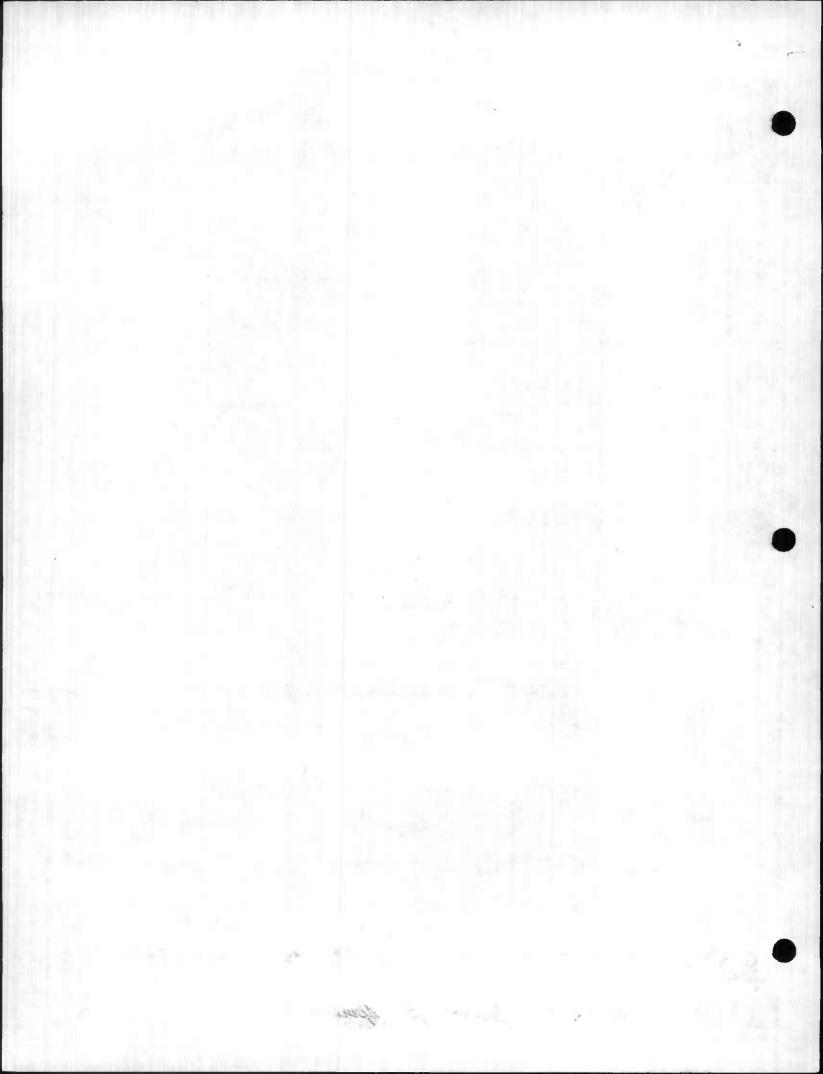
31. Dete filed (Month, Day, Year) State Registrar

JUL 2 9 1999

Robert Lyden

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 6801 Belair Rd Baltimore, MD 32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene QQ

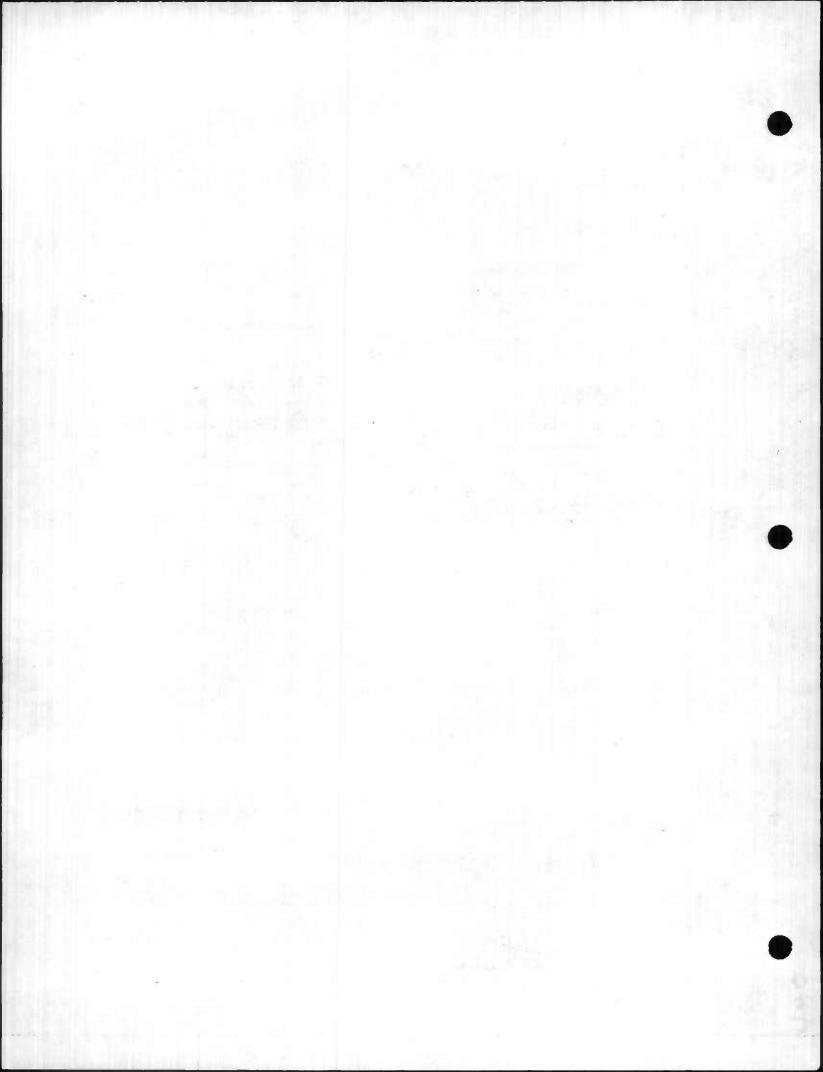
23894 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day **Physician** July 20 1999 22:22 Abbie M. Kratz /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore City | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | MAY 30,1902 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 M 2 KF Yrs. 97 Virginia Director 216-01-8136 Atient Known Hs: Abbie Usual Residence of Decedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21218 U.S.A. 3014 Frisbe Street Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 1 Yes 2 No Specify: Specify: White þ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then any Injury or other traumatic event. In a manual control or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Insurance Company 12th Grade 2 Yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cora J. Meadows Marcellus Meadows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7934 Court House Road - Spotsylvania, Va. 22553 Joyce M. James (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/23/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Furieral Service Licens Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue - Baltimore, Maryland 21229 23a 2 rt. Enter the disease, or complications that caused the dearly. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediate Causa (Final 1 hr SEPSIS diseasa or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner sician and burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of): attending 080 ed by the at detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. signed by t 3 Probably 4 Unknown 1 ☐ Yaa 2 ☑ No Diabetes p 24b. Ware autopsy tindings available prior to complation of causa ot death? Completed 24a. Was an autopsy performed? Hypertension Deen has page 2 1□ Yes 2□No 1 ☐ Yas 2 ☐ No of Vitai 25. Was case rafarred to medical examinar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☐ No 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 🖾 Naturat 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending invastigation Division Attending death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 2 4 Homlcide Hospital of 24 hours a Funeral D 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) \mathbf{z} 29b. Signature and titla of certifies. 29c. License number 29d. Data signed (Month, Day, Year) 7/21/1999 D0021730 iami son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Sinai Hospital, 2401 W. Belvedere Avenue, Balto. Md. 21215 Tariq Khan 31. Gold filed Mogn, 1999 gear) 32. Registrar's Signature State

DHMH 16 Ray 6/95

Registrar

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Division

To the Hospital or Attandil within 24 hours after death. To the Funeral Director: A completely filled in by the fu edical Registrar

State

29c. License number

O.C.M.E

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 05 , 1999 JULY

and address of person who completed cause of death (item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

BALTIMORE, MD

31. Date liled (Month, Day, Year)

29b. Signature and title of certified

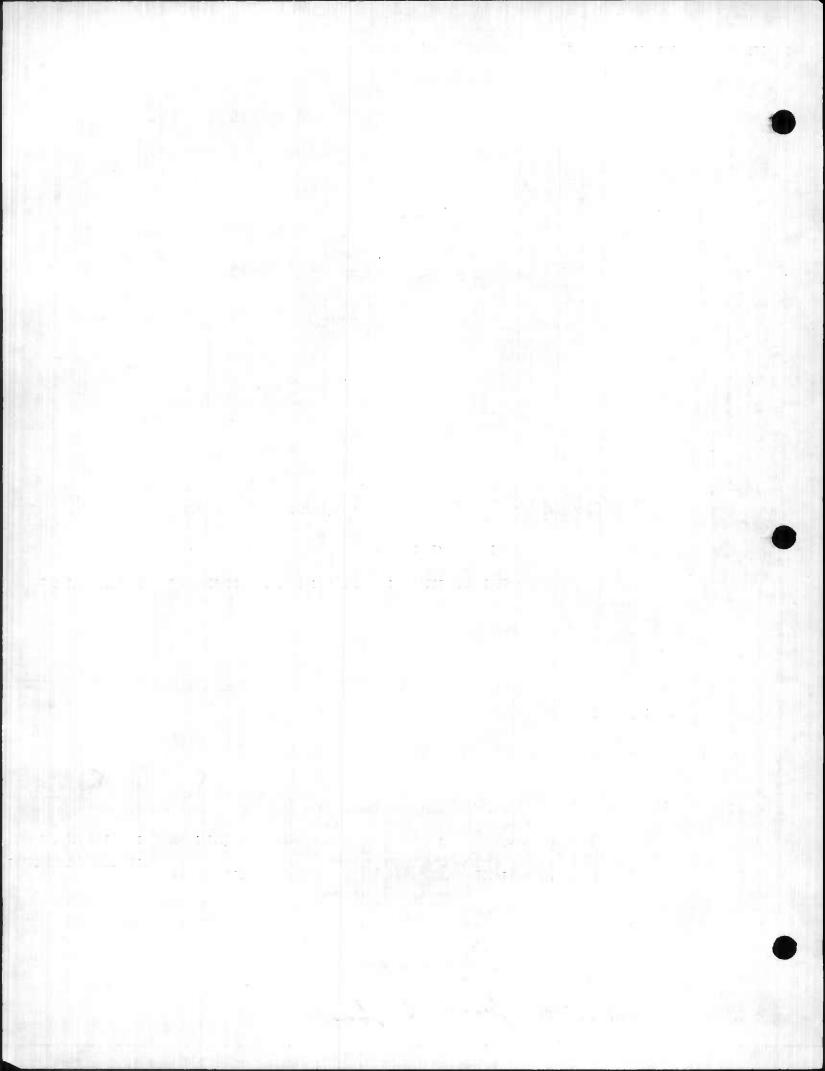
29a. Certifier

(Check only one)

> 29 1999 JUL

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and (o) yers 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 23896

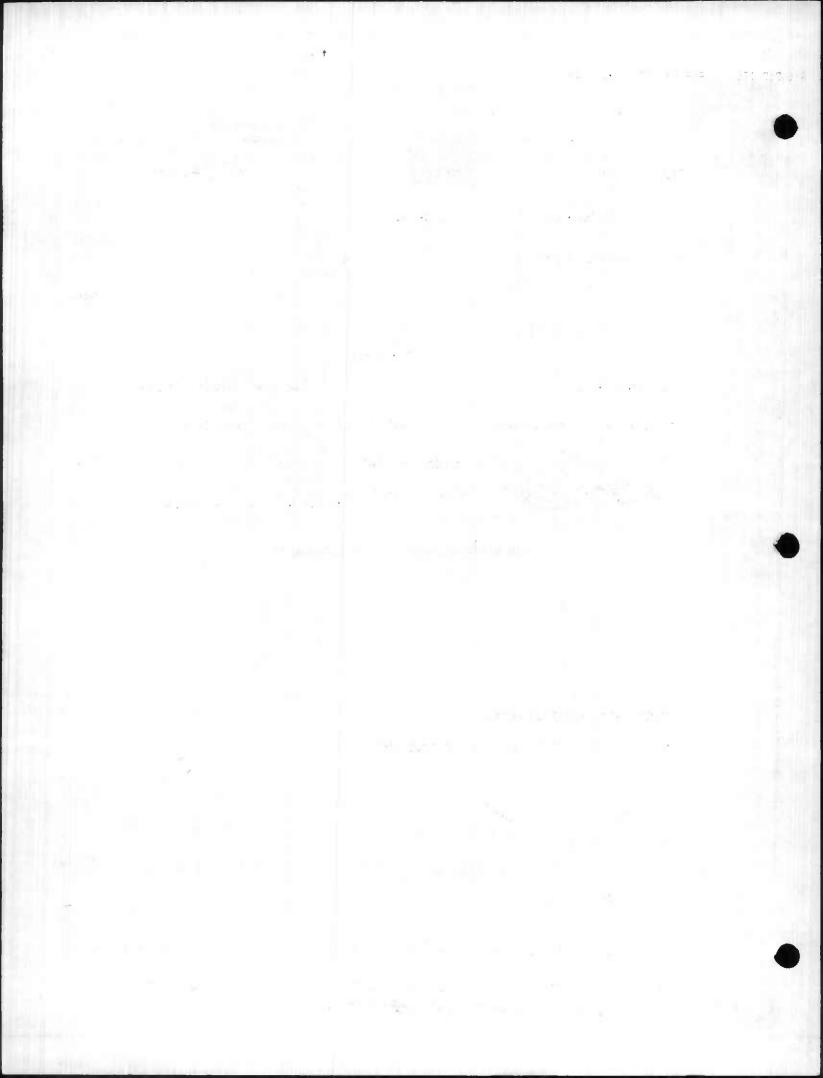
		Certificate of Death	Reg. No.	
Physician	1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Day,	Year 3. Time of Death
/Medical	Willie Moore		July 26th	1999 66.62
Examiner	4a Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL [5. Sociel Security Number] [6. Sex , [7. Age (In yrs. last birtho	4b. City, Town, or Loc	O HOWAI	RD
Funeral Director	S. Sociel Security Number 8. Sex 10 M 20 F 7. Age (In yrs. last birtho	Months Days Hours Min.	6. Dete of Birth (Month, Dey, Year) 11-28-24	Birthplace (Stete or Foreign Country) A
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ifier death with the Ma free 23a or 28e-1s instrument be profiled. Funeral Director	109. Street and Number 1409 B. WHEATON PLACE	101. Zip Code 21228	10g. Citizen of V	
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	17. Father's Name (First, Middle, Last) DAVID MOORE	18. Mother's Neme	(First, Middle, Meiden Surnem	
C C N L	PRISCILLA MOORE WIFE 409	eiling Address (Street and Number or Rural		
A H H A	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ☐ GARRIS		Date 20c. Location - 3.2.99 Owns	City or Town, Steta Mius MO
permit. Pe Departmen Important any Injury	Vangue Huge	22. Neme end Address of Facility VAUGHN C. GREENE F 5151 BAUTO, NATU PIKE	E, BALTO, MO.	212.29
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Examiner	diseasa or condition resulting in death) a. Oue to (or as a cor	isequence of):	<u>L</u>	1 Nou
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Attending Independent of the funer of the fu	27. Manner of Death 1 Shatural 5 Pending (Month, Day Year) 28a. Dete of Injury (Month, Day Year)			
To the Hospital or Attending Physician 24 hours after death, within 24 hours after death, completely filled in by the funeral completely filled in by the funeral Medical Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, ferm building, etc. (Specify)	street, tactory, office 2	8t. Location (Street and Numb City or Town, State)	per or Rural Route Number,
the Hospi in 24 hou the Funer pletely fill	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, do not be basis of examination and/or end manner steted.		d at the time, date and place,	and dua to the cause(s)
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	3459 ST yoling Fa	po, Print) Ellicoff	City had.	21042
State	31. Dete tiled (Month Day Year) 32 Registrar's Signeture	1	Λ	

DHMH 16 Ray 6/95

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Important: If item 27 is any injury or other tra	-	21. Signature of Eugeral Sarvice Lice		- Dalane,		Addrass of Fecilit		CIII	1 11110111	idiii, 1	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #18 PER FH G773 7/29/99 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death **Physician** Month Scott Edward Porter 26 6:30 AM 07 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner trankl Baltimore Sa 7. Age (In yrs. last birthday) osedal enter vare 10 If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1₩ 2□F Days 217-03-6770 88 Director 29, Dec. 1910 MD, Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or itema 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at Yas 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3928 HUDSON ST. 21224 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, atc. permit. Peges 1 and 2 should be filed within 72 hours effect. Department of Heelth and Mentel Hyglens. Important: If New 27 is marked other than "natural". A phone. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 POLICEMAN BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) CLARA UHLER ALEXANDER PORTER CLARA WHLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) MARTHA PORTER/WIFE 3928 HUDSON ST., BALTIMORE, MD. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slata 1 Burial 2 Cremation 3 Removal from State STANISLAUS CEM. 7/29/99 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility CHARLES S. ZEILER & SON, INC. 23a. Part1. Ents/ in disease, or complications that caused the death. Do not entar the mode of dying, such as carriac or rest, iratory arrest.

MD proximal a 2.24 shock, or heart failure. List only one cause on each line. Inlarval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical year Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and the buriel-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760 that initiated events resulting in death) Last Due to (or as a consequance of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 94 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed by it by been si 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy hes TI Yes ZUNO 1 ☐ Yes 2 ☐ No certificate Division of Vital Physicien: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 10 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No edical Certification: To this After the 27. Manner of Des Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation or Attending 1 Natural n 24 hours effer death.

Ne Funeral Director: After pletely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 T Homicide Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the Vithin 2 29b. Signature and title of ceptifies 29c. License number 29d. Date, signed (Month, Day, Year) MD Square

Registrar

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31. Data filed (Month,

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Day, Year)

32. Registrar's Signatura

Funeral

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Hygiene.

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21215-0020

Saltimore, Maryland

Box 68760.

P.O.

Records,

of Vital

Division

The law requires that the death certificate be

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** DONALD PINKNEY 25, 4b. City. Town, or Location of Death 1999 12:01 A.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 4500 Block of Garrison Boulevard Baltimore If Under 1 Year Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) Months Days Hours 10XM 20 F 9-23-75 MD 215-86-2411 Usual Rasidence of Decedant 10a Stata 10h. County 10c. City, Town or Location 10d. fnside City Limits MD. N/A BALTIMORE 1 XYas 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21216 3237 WESTMONT AVE. USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐XNo If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Eiamentary/Secondary (0-12) Collega (1-4or 5+) -12--1-ARTIST GRAPHIC 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be NORVELL W. PINKNEY KIM PINKNEY 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a, Informant's Name/Relationship (Type, Print) CECELIA PINKNEY (GRANDMOTHER) 3401 POWHATTON AVE. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-31-99 BALTIMORE, MARYLAND WOODLAWN CEMETERY eture of Funeral Service Licensee 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata interval Batween Onset and Death Immediata Causa (Finai Gunshot Wounds of the Head and Neck disaasa or condition rasulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 M Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 X Yas 2 □ No 1 X Yas 2 No 25. Was casa rafarred to medical 26. Place of Death (Check only ona) axaminar? 1 XYas 2 ☐ No Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Residence 6 Dother (Specify) SCENE Certification: To 2 ER/Outpatient 3 DOA 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of fnjury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Naturai 5 Pending 1 Yas 2 XNo Subject was shot. invastigation 11:51 PM 2 Accidant 07-24-1999 6 Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicida 281. Location (Street and Number or Ryral Routa Number, City or Town, Stata) 4400 BLOCK Of 4 X Homicida Street Garrison Blvd., Baltimore, MD 29a. Certifier Medicai 1 Certifying Physician: To tha best of my knowledge, daath occurred at the tima, data and place, and due to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

Attending Physicien: death. 24 hours after deal Funeral Director: filled in by 8 Hospital npletely within 2 To the \$ 0

> State Registrar

31. Data filed (Month) Ann Dixon M.D. L 2 9 1999

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29b. Signatura and title of certifier

30. Nama and add

32. Registrar's Signatura

ss of person was completed causa of death (itam 23a) (Type, Print)

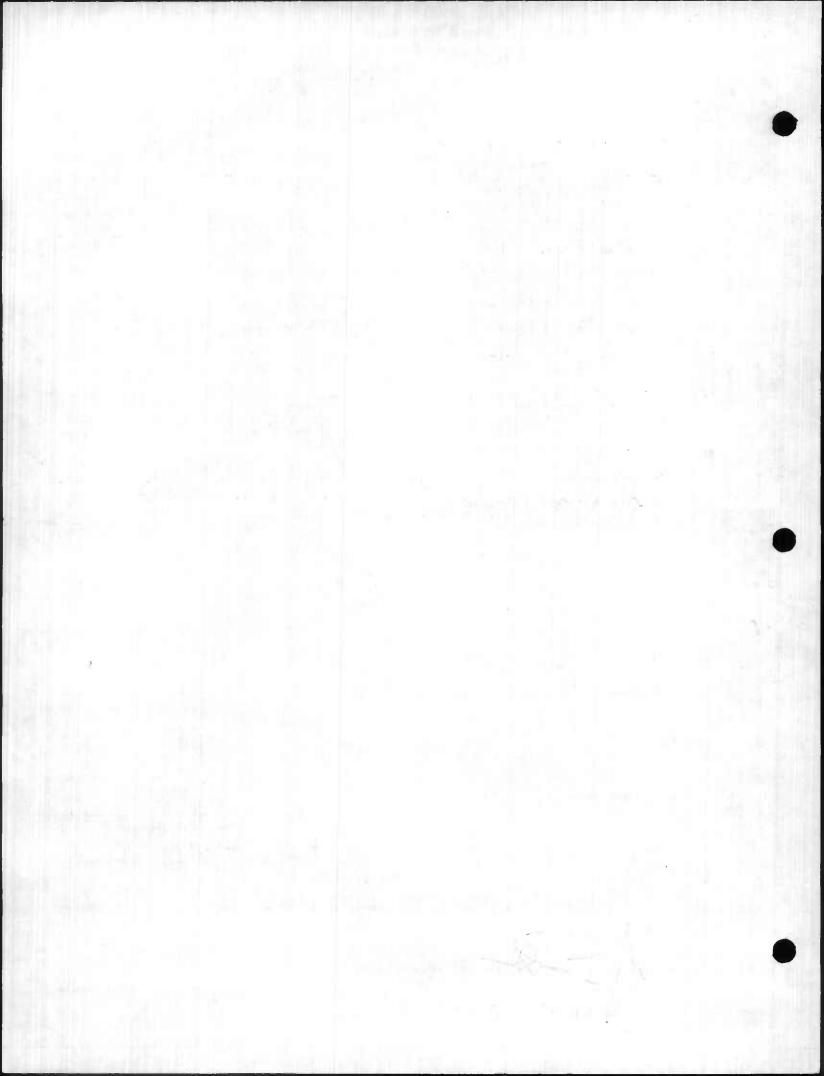
111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Data signed (Month, Day, Year)

July 28, 1999



permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baitimore, Maryland 21215-0020

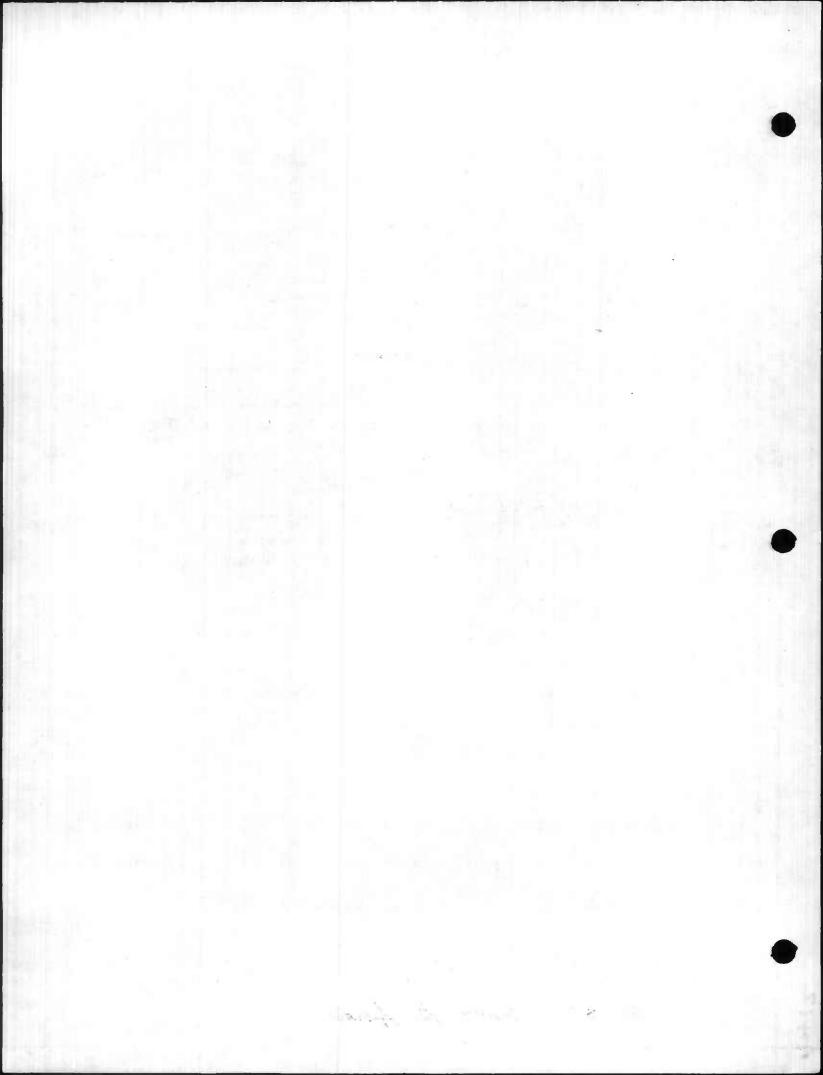
Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indeible Ink. Assure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

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Gloria J. Quick 4a Facility Name (if not institution, give street end number) 4b. City, Town, or Lot											1000 111
1912 CASADEL AVENUE BALTIMORE										/A	
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Maryland N/A Baltimore								}	1 XXes 2 □ N		
10e. Street and Number		Α		Darci	10f. Zip Code				10g. Citizen of	What Cour	ntry?
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Richard L								ellie			
19a. Informant's Name					lling Address (Stree						
Rose C. V		n (Daugh			Stuarts position (Name of	Ridge	Road	-			.C. 27587
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Registrar



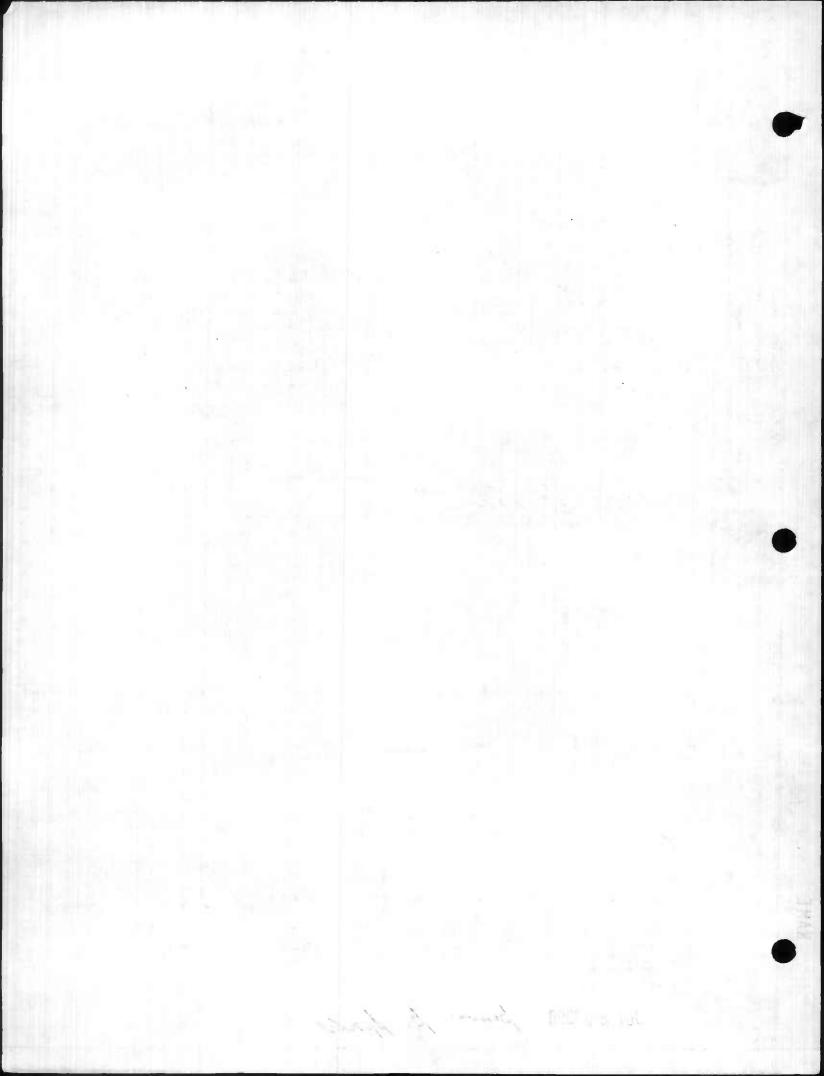
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Nama (First, Middla,	Last)	Ce	rtificate of	Death	2. Data of De	Reg. No.	3. Time of Dr	eath
Physician	Rial N. Rose					Month July	Day	Year 919 23:01	
/Medical Examiner	4a Facility Nama (If not institution,	giva street and number)			4b. City, Town, or L.	-			
Examine	SAINT AGNES	HOSPITA			BALTIN	PORE			
Funeral			a (In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs.	8. Data of Bi		9. Birthpiace (State or F Country)	oreign
Director	Usual Rasidence of Decedant		85 Yrs.			pune 2.	2, 1914	Missouri	
a or 28a-f show be notified at	10a. Stata 10b. County		10c. City, Town or L	ocation				10d. tnside City	
28a-f sho noutfied at	Maryland Baltim	ore	Baltimon	ce				1 🗆 Yas 2	MO NO
O M O	10e. Street and Number			10f. Zip Code			10g. Citizen of \		
s 23a	707 Maiden Choic		_		228		U.S		
ar, or items 234 Executor ment by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forcas? 13 Yas 2 I If Yas, Giva Yaar or Datas:	No	was Decedent of a life Yas, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp san, Mexican, Puerto Specify:	Pican, etc.)		e - Amarican Indian, ck, Whita, atc. white	
"natural",	15. Decedant's	Education	16a, Dece	dent's Usual Occu	pation		16b. Kind of B	usinass/Industry	
r, the Medical Completed	(Specify only highast s Elementary/Secondary (0-12)	Collega (1-4or	5+) (Give	DO NOT use retire	during most of worked)	ang			
vent, the Man ve		unknown	unkı	nown			unknow	n	
Be very	17, Fathar's Nama (First, Middla, La	•			18. Mother's Nam			na)	
To	Dean Humboldt Ro	se			Edith	June N	Velson		
E E	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street	t and Number or Rui	ral Routa Numb	ber, City or Town,	Stata, Zip Code)	
or other traumatic event, To Be C	unknown		20b. Place of Disp	inknown		0.11		00 - T 01-1	
	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Department 5 Other (Spe		cemetery, cre	matory or other pla	108)	Date	20c. Location	City or Town, Stata	
any injury DOGS.	21. Signature of Funeral Service Lic Joseph	B. Van Semi	1-11	2.Nama and Addre State Ana Baltimore	tomy Boar		W. Balt	imore Street	
ician dical niner	23a. Part1. E is tha disaasa, or co shock, or haart failura. List on Immediata Causa (Final disaasa or condition rasulting in death)		Crania			or respiratory (arrest,	Approximate Interval Batwe Onset and De	en ath
ner ner			Due to (or as a conse	quence of):					
physician and street the burist-transit	Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated events	b	Due to (or as a conse	quence of):					
2 2	Cause (Disease or injury that initiated events rasulting in death) Last	С.	Dua to (or as a consec	quence of):					
detached for use a		d							
the a	Part It. Other algnificant conditions	contributing to death b	ut not resulting in the u	inderlying cause gi	iven in Part t.	23b. Did	tobacco use co	ntribute to the cause of	death?
be detached for use by Physician/M						10	Yaa 2 No	3 Probably 4 Ur	ıknown
2 should						24a. Was perf	s an autopsy ormed?	24b. Were autopsy find available prior to completion of cau of death?	
s certificate hes director, page 2 To Be Comp						10	Yes 200 No	1 ☐ Yes 2 N	0
Be C	25. Was case referred to medical				26. Place of Deal	th (Check only	one)	/\	
D 0.0	examiner?	Hospital:	ent 2 ER/Outpatie	nt 3 DOA Ot	her: 4 Nursing Ho	oma 5 🗆 Res	idence 6 🗆 Oth	ear (Specity)	
After the funeral funeral fon:	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigat	28a. Dete of Inju (Month, Da)	ry 28b. Tima o	Wo	ny at ork?] Yes 2 □ No	28d. Describe	how injury occur	red	
ed in by t	3 Suicide 6 Could not 4 Homicide determine	d 28a. Place of inj	ury - At homa, farm, st c. (Specify)	reet, factory, office		28f. Location City or To	(Street and Numb own, Stata)	per or Rural Route Numbe	ir,
To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sto	examinetion end/or in	h occurred at the ti	ime, date and place, opinion, deeth occur	and due to the red at tha time	cause(s) and ma , data and place,	annar as stated. and due to tha cause(s)	
N N	29b. Signatura and titla of certifier	,		29c. Licen			29d. Data signe	d (Month, Day, Year)	
		renster ma			5 90		July 2	6,1999	
	30. Nama and addrass of person who	o completed causa of d	4		Himore, Ma	د لسای	21229		
State	31. Data filed (Month, Day, Year)		ar's Signatura	1/10	-117-070, 110	1.01			
State	40.0	-							

Registrar

JUL 2 9 1999

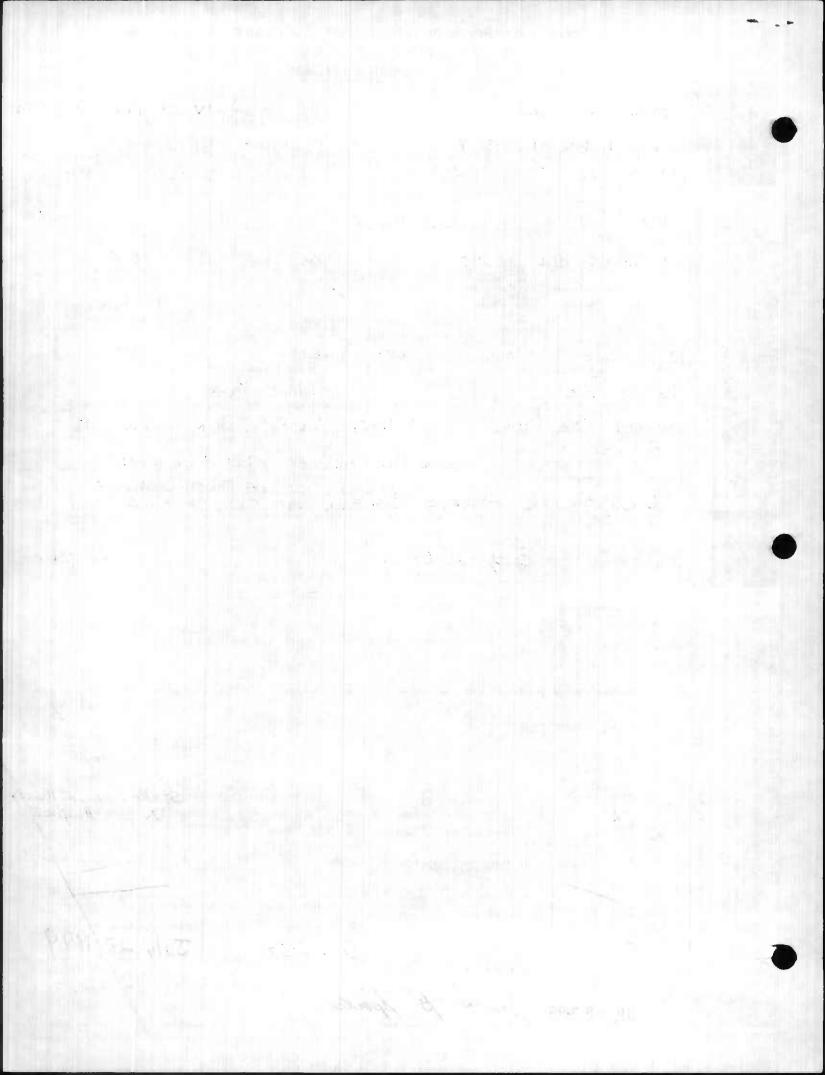
B. Sparks



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Physician 1999 10:10am HERMAN Jul 28 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) Examiner BALTIMOR If Under 24 Hrs. NIA MARIS MERCY **OTELLA** AT If Under 1 Yeer Birthplece (State or Foreign Country)
 MD 6 Sev 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In vrs. lest birthday) **Funeral** 10 M 2 D F Min Months Deys Hours Yrs. 214-20-2922 Director Usuel Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exattrines main be incitled as 1 ☐ Yes 2 ☑ No BURNIE Director MO 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21060 401 AVENUE MORRIS Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
nt: if item 27 is marked other than "natural", or items 23. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 No If Yes, Give Yeer or Dates: 14. Rece - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK altimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) MTA DRIVER 12 TH GRADE NA 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father'e Neme (First, Middle, Last) Be KOSE Young MARIE OL HERMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21000 19e. Informent'a Neme/Reletionship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any Injury or other trau BARBARA GLEN BURNIE 401 MORRIS KOSE WIFE 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 20e. Method of Disposition 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 7-31-99 BALTO, MD 4 ☐ Donetion 5 ☐ Other (Specify) HILL CEMESERY 21. Signeture of Funeral-Service Licensee 22. Neme end Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. BALTO. MO. 21229 Approximete Interval Between Onset and Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical **Examiner** De to (or as a consequence of): Examiner physician and the bunal-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) cartificata be axed Box 68760. Physician/Medical Due to (or es e consequence of): 88 usa jo 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. datached 3 Probably 4 Unknown 1 TYee 2 No signed t þ 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy Completed completion of cause of death? paga 2 has 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificata or Attending Physician: 26. Place of Death (Check only one) STELLA MARIS AT MERCY funaral director. 25. Wes case referred to medical exeminer? Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSDICE 2 1□ Yes 2NNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of Certification: Injury et Work? Aftar 1 Naturel 5 Pending Injury after death. Director: Aft 1 ☐ Yes 2 ☐ No investigetion **€** □ Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a Hospital Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and menner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) , BA/tiMORE RISEDE Rg DAVID 31. Dete filed (Month, Dey. Year)
JUL 2 9 1999 32. Registrar's Signetur State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Time of Death 2. Data of Death TIILY 24 Day 1988 23:45 RODGERS KAY

Physician /Medical Examiner 1. Decedent's Neme (First, Middle, Last)

Funeral

Director with the Maryland r 28a-f show inotified at r than "naturel", or items 23s or the Medical Examiner must be r

Director

Peges 1 and 2 should be filed within 72 hours after death a neat of Health and Mental Hygiene.
Instit if team 27 is marked other than "naturel", or Itema 23, mir. if item 20 was the west than a stude of the manual or or other traumatic event, the Wedice Example must you other traumatic event, the Wedice Example must Department of Important: If any injury or

3altimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner

Physician/Medical

Completed

Be

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Certification:

Medical

sician end burial-transit the death certificate be executed Box 68760. physician the buria 98 980 P.O. ed by the a signed b Records. page 2 has certificate Division of Vital this funeral After

Attending Physicien: death. after deat filled in by ò 24 hours To the Hosp within 24 hos To the Fune completely fi

BARBARA 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE THE JOHNS HOPKINS HOSPITAL N/A If Under 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) OCt. 1, 1942 5. Sociel Security Number 7. Aga (In yrs. lest birthdey) 9. Birthpleca (Stata or Foreign Months Deys Hours 1□M 25 F 56 Yrs. Indiana 309-46-8730 Usual Residence of Decedent 10e State 10h Count 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore MD N/A 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number United States 21222 6716 Youngstown Ave Funeral 14. Race - Amarican indian, Black, Whita, atc. 12. Wes Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☑ No If Yas, Giva Yaer or Detes: 1 ☐ Nevar Merried 2 ☐ Married Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) Elemantery/Secondery (0-12) College (1-4or 5+) Education Teacher 12 18. Mothar's Neme (First, Middla, Maiden Sumama) 17. Father's Neme (First, Middle, Last) Kathryn Eleanor Kipp Herbert Charles Stafford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) Baltimore, MD 21222 6717 Youngstown Ave Susan Rodgers/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Steta 4 ☐ Donetion 5 ☐ Other (Specify) 7-29-99 Green Mount Crematory Baltimore, MD 22. Nema and Addrass of Facility 21. Signature of Funeral 8 CAFA Stephen D. Lohrmann P.A. 23a. Pert1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line. 8717 Green Pastures Dr., Baltimore, MD 21286 Approximata intarval Batween Onset end Deeth immediate Cause (Finei disaasa or condition resulting in death) FOUR HOURS AORTIC RUPTURE Due to (or as e consequence of): Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part ii. Other algorificant conditions contributing to deeth but not resulting in the undarlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION þ 24b. Were autopsy findings available prior to 24a. Wes an autopsy completion of cause of death? 1 Yes 2 No XIYes 20No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

27. Menner of Deeth

1 Neturel

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29c. License number

28c. injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES

1 ☐ Yes 2 ☐ No

000

28b. Time of

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) JULY 24, 1999

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) PETER J. GRUBER 600 NORTH WOLFE STREET

28a. Dete of Injury (Month, Dey Year)

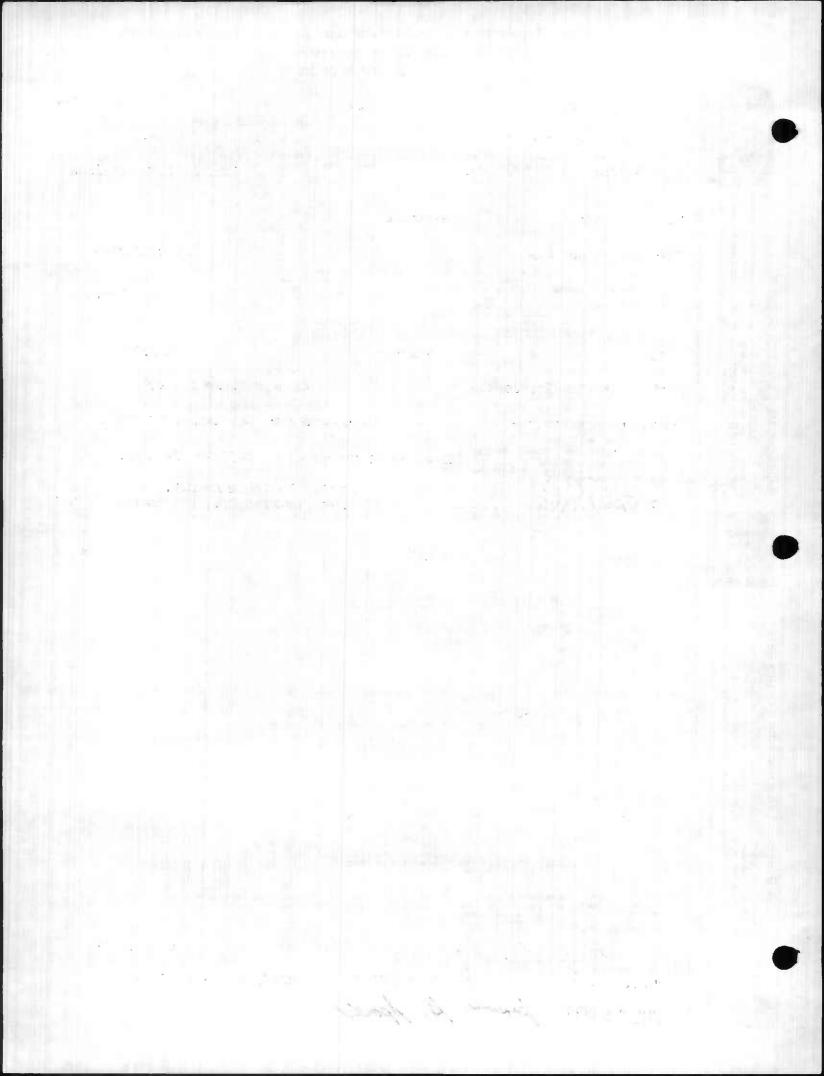
BALTIMORE, MARYLAND

28d. Describe how injury occurred

State Registrar

31. Deta filed (Month, Dey, Year) 2,9 1999





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Deeth 3. Tima of Death **Physician** Rolfes avian 20:55 July /Medical 4e. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Death Keswick Multi Care Center Baltimore N/A 5. Sociel Security Number If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Deys 1□M 2□F 219-40-8358 86 Yrs. 1913 Connecticut Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits Director t Yas 2 No N/A Baltimore 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? 3610 Elmlev Avenue 21213 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 1 ☐ Yas 2√☐ No If Yas, Give Yaar or Datas: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2√☐ No p Specify: 3.☐Widowed 4 □ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Sales Hutzlers Dept. Store 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Maiden Sumema) Be Luigi Comi Conchetta Grenda 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Dick Rolfes 56 Steeple Chase Drive Doylestown PA, 18901-5708 20b. Pleca of Disposition (Nama of camatery, cramatory or other pleca) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Steta 1 D Burial 2 □ Cremetion 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Holy Redeemer Cemetery 22. Name end Address of Facility 7/28/99 Baltimore, Maryland 21. Signetura of Funaral Sarvice Licansee 23a. Part 1. Enter the disease, of complications that caused the grath. Do not entar tha moda of dying, such as cardiac or raspiratory arrest,

Approximate Interval Batween Consett and Death C Dippel Funeral home Inc. Immadiata Cause (Finai LIROSEPSIS diseasa or condition rasulting in death) Examiner incontinence Sequentially list conditions, if eny, laading to immediata causa. Entar Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Last Dua to (or as a consequance of): Physician/Medical Dua to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown þ Completed 24a. Wes an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death? 1 Ves 2 David 1 Yes Z No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification: To 1 Yes 2 No Other: 4 viring Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Daath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Natural 5 Panding Investigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datermined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homiclde Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and mennar stated. Medical 29a. Cartifier 29b. Signeture and this of certifier 29c. License number 22334 30 me apo ddres person who co.... se of death (Item 23a) (Type, Print) toth Str BALTIMORE 700 W (1050 Data filed (Month, Day, Year) 2. Registrar's Signatura JUL 2 9 1999

State Registrar

Funeral

Director

28a-f show must be notified at

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items 23a

"natural", or

should be filed within 72 hours end Mental Hygiene.

marked other than "natural", o

Pages 1 and 2 should be nent of Heelth and Mental

permit. Pages 1 and 2 shr Department of Heelth and Important: If item 27 is m any injury or other traum once.

Physician /Medical

Examiner

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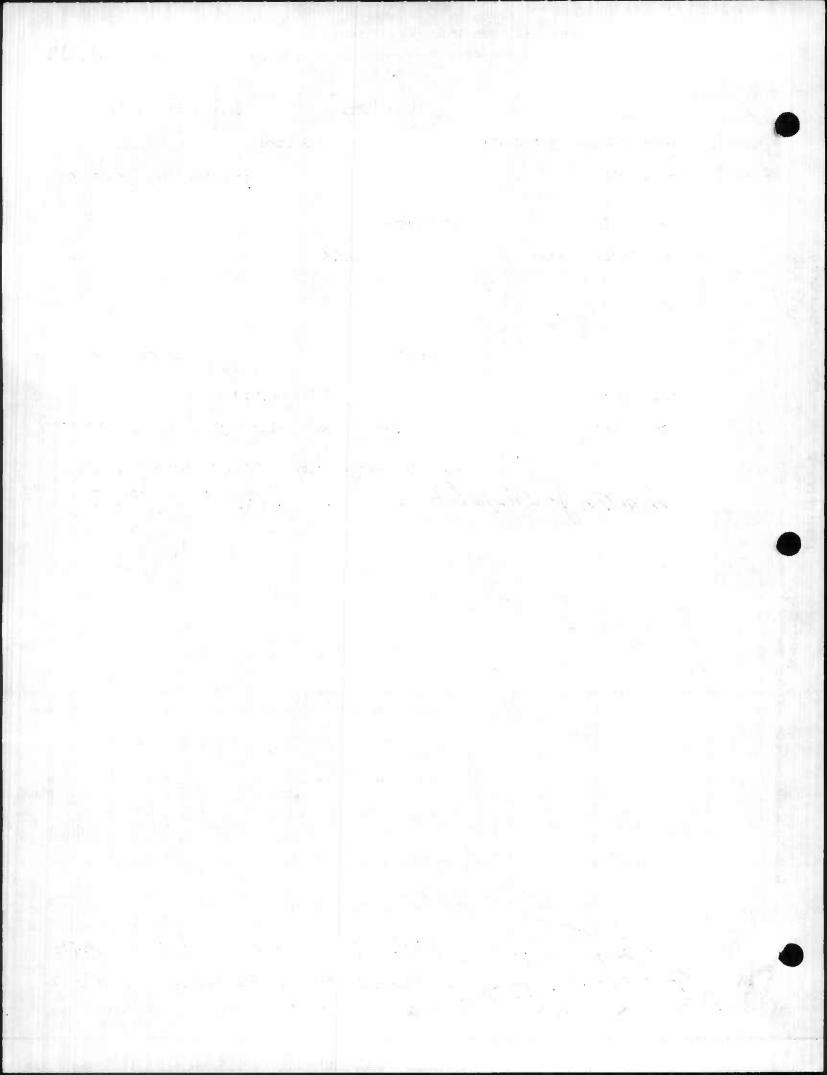
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ROLFES

ARIAN.

21215-0020

Baltimore, Maryland



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) SPENCER WILLIAM 12:30 AM TOWARD 041 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) BAYVIEW HOSPITAL

7. Age (In yrs. lest birthday) If Under 1 Ye HOPKINS THORE JOHN If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Security Number 6 Sex Birthplace (Stata or Foreign
 Country) 1XM 2□F Months Days 215-19-4990 Usual Rasidanca of Dacadant Yrs. 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1. Yas 2 □ No MARYLAND 10e. Street and Number Citizen of What Country? 311 USA. 14. Race - American Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 11 Marital Status 1 Yas 2 If Yas, Giva Yaar or Datas: 1 Never Married 2□ Married 2 No 1 Yas 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) STEVADORE WATER FRONT 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) UNKNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) BALTIMORE, M.D. 2/2/3

a 20c. Location · City or Town, Stata 4311 CFRIEND. -UCILLE BROWN AREWAY Data 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from State ARBUTUS CEMETERY 4 Donation 5 Other (Specify) 21. Signatu Fun ral Service icensea

22. Nama and Address of Facility

23. Part1. Inter the disease, or complications that ceusad the death. Do not anter the mode of dying, such as cardiac or respiratory efrest, shock, or heart failure. List only one cause on each line. BROWN JR. FUNERAL BALTIHORE Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in death) Arterio scleratic Cardio vasculor Dua to (or as a consequence of): Hypertension 25 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated avents resulting in death) Last Dua to (or as e consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 XINO 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Physician /Medical Examiner

Physician

* /Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after deeth on and Mental Hygiene.
Is marked other than "natural", or items 23

permit. Pages 1 and 2 st Department of Health enc Important: If item 27 is n

Injury or

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Baltimore, Maryland 21215-0020

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Examiner physician end s the burial-trans esn

8 certificate has

Physician/Medical by Completed Be 10 Certification:

P.O. Box 68760 Division of Vital Records. Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certifical funeral

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Deeth 1 Neturel

2 Accidant

3 Suicida

29a. Certifier

4 Homicide

5 Panding invastigation 6 Could not be datarmined

28a. Date of Injury (Month, Day Year)

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28b. Time of

28c. Injury at Work? 1 Yas 2 No 28d. Dascribe how injury occurred

Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29c. License number

29d. Data signed (Month, Day, Year)

30. Nama and a grass of person who for the ted ceuse of death (Itam 23a) (Type, Print)

AUH76435 K9263

Kelsey, M.D. S. Paca 29

Riba filed (Month, Day, Year)

JUL 2 9 1999

32. Registrar's Signatura

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State Registrar

Medical

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Defe of Death Month **Physician** ,45Am DANIE 20 01 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Bon Secour Hospital Baltimore
If Under 24 Hrs. If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1₩ 2□ F Months Deys Hours Min. Yrs. 89 Director 186-07-7990 Oct. 24, 1909 New Jersey Usuel Residenca of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Exercise must be not? at any 10,000. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1913 Wheeler Avenue 21216 U.S.A. Funeral 14. Rece - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Owner/Broker Reality Company 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) Henry Wilson Spaulding Hatte Lefticia Moore 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Hazel Spaulding/spouse 1913 Wheeler Avenue, Baltimore, MD 21216 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Ronald S. Wad Director State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, mock, or heart feliure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** ACUTE MYOCARDIAL IN FANCTION /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner ACEMAICER physician end the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai that initiated events resulting in deeth) Last Due to (or es e consequence of): 98 ettending for use es signed by the e 23b. Did tobecco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 Nonknown by 24b. Were autopsy findings evalleble prior to completion of cause of deeth? been si 24e. Wes en eutopsy Completed performed? has e 2 s certificate has 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after deeth.
 Funeral Director: After this certifical eleby filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Quaturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigetion 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. 29e. Certifier edicai pletely To the I Within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certifier 29c. License number 1100 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) OLDORENS ROAD/30LT

RABHAICAR M.D 2115

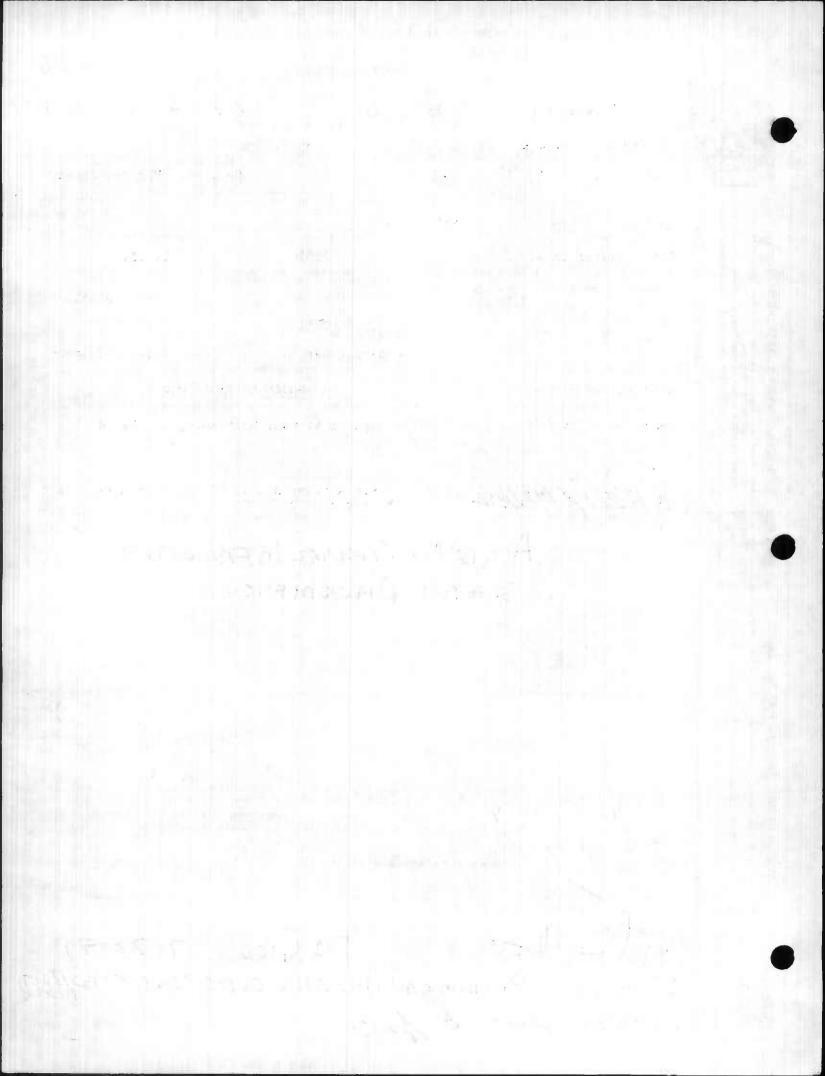
32. Registrer's Signeture

Registrar **DHMH 16 Rev 6/95**

State

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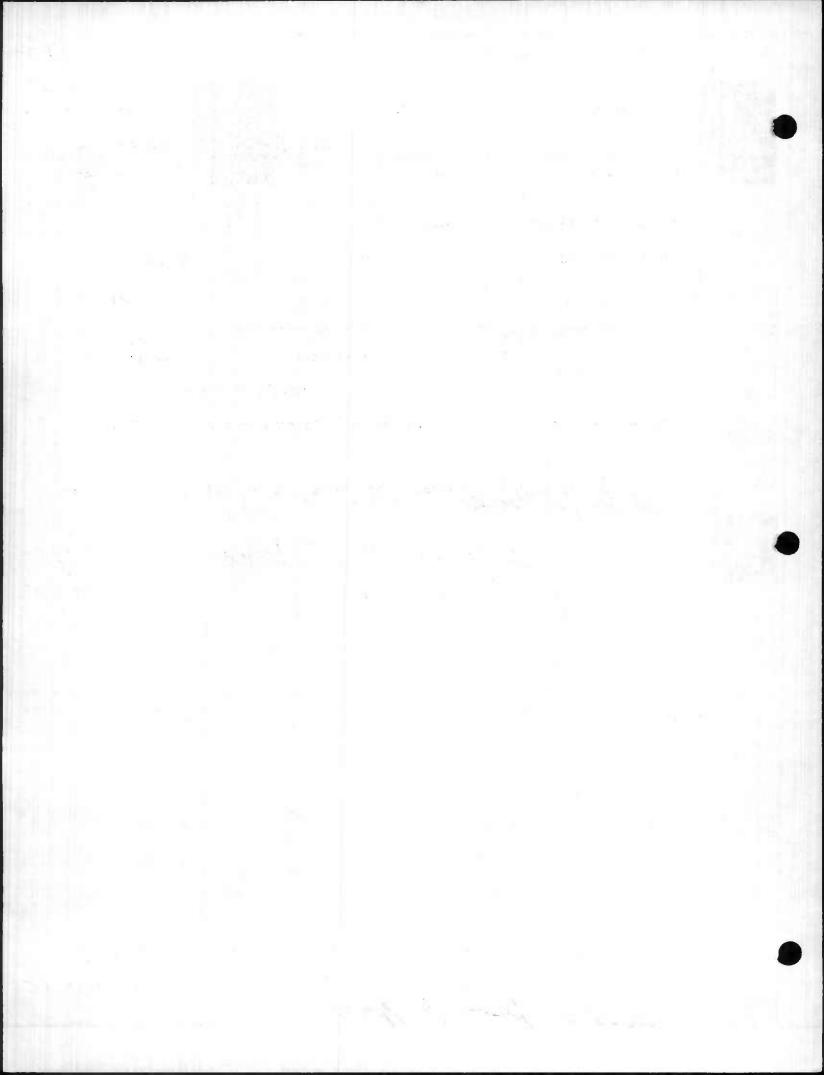
31. Dete filed (Month, Day, Yeer)



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State of Maryland / Department of Health and Mental Hygiene 9 9 2 3 9 0 7

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ar	2 should end Men Is marke		19a. Informant's Name/Relationship (7)	ype, Print)	19	b. Mailing Addre	ess (Street	t end Number or A	ural Routa Numb	er, City or Town, S	Stata, Zip Code)
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	41		31. Date tiled (Month, Day, Year)	82 Panistrar	's Signature	N. 10	1001	YUN	N	·, wis	TEXO!	VILLE
F	Sta Registr		11. Date thee (Mortal, Day, 18al)	Te de la la la la la la la la la la la la la	1	Loon	Kal	-				



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month 3. Time of Death Day **Physician** JUNE 13, 1999 5:57 PM NASEEM N. SALTRA /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex 1**X** M 2□ F 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Yrs 86 **Director** 254-18-7716 MAR. 2,1913 LOUISIANA Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow ? Is marked other than "natural", or Nems 23s or 28s-f shot traumstic event, the Medical Experime, must be notified at 1 ¥ Yas 2 □ No MACON BIBB Direct 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 2572 OLD HOLTON ROAD 31204 U.S.A. Funeral 72 hours after death 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indian Black, Whita, atc. 1 Yas 2 □ No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 Yas 2 No Specify: þ 3 ₩ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72.1 Department of Health and Mental Hyglena. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Heal case page. 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOVERNMENT CARTOGRAPHER 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) CHARLOTTE NASSER MELHAM **ABRAHAM** 19a. Informant's Name/Relationship (Type, Pnint) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , ARLINGTON, VA. 22207 2715 N. 24TH ST. DALE SALIBA (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ramoval from State 6/18/99 MACON, GA. MACON MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee JOSEPH GAWLER'S SONS 5130 WISC. AVE. Jonlaker Inomas WASHINGTON, DC. 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Multiple injuries with complications /Medical Immediate Cause (Final disaasa or condition resulting In death) Examiner Examine physician and the burial-transit certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. e da 2 1 Yes 2 No 3 Probably 4 Unknown signed b p Records, 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peed completion of ceuse of death? The law has 2 No 1 ☐ Yas 2 ☐ No cartificata Division of Vital Physician: Be 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 11XYes 2□ No this funaral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Certification: After or Attending 1 Natural 5 Pending 1 Yes 2 No daath. investigation 9:05A M CRASH OF PRIVATE PLANE 2 Accident 6/02/99 Director: 8 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by aftar 4 Homicide TREES JUST EAST OF AIRPORT CLINTON, MD To the Hospital of within 24 hours at To the Funeral D complately filled in edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month. Day, Year)

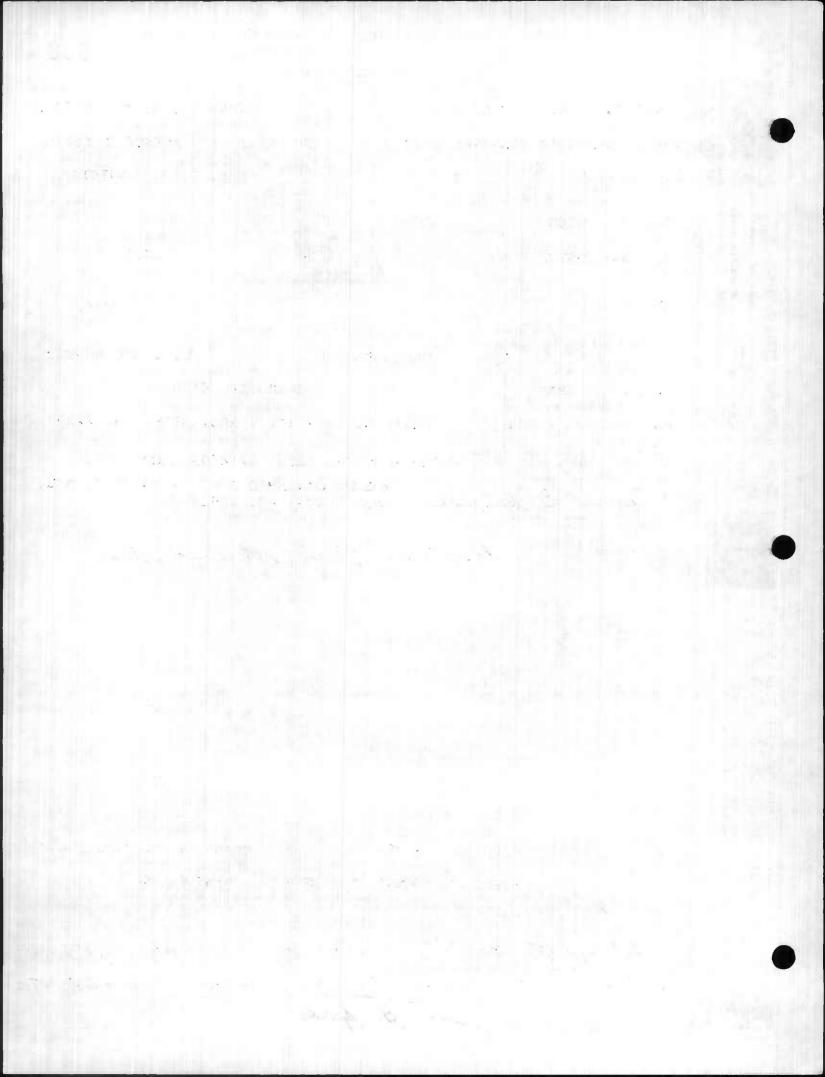
Hoggital Drive Cheverly, Maryland, 20783

State Registrar 30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)

20

3001

32. Regietrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

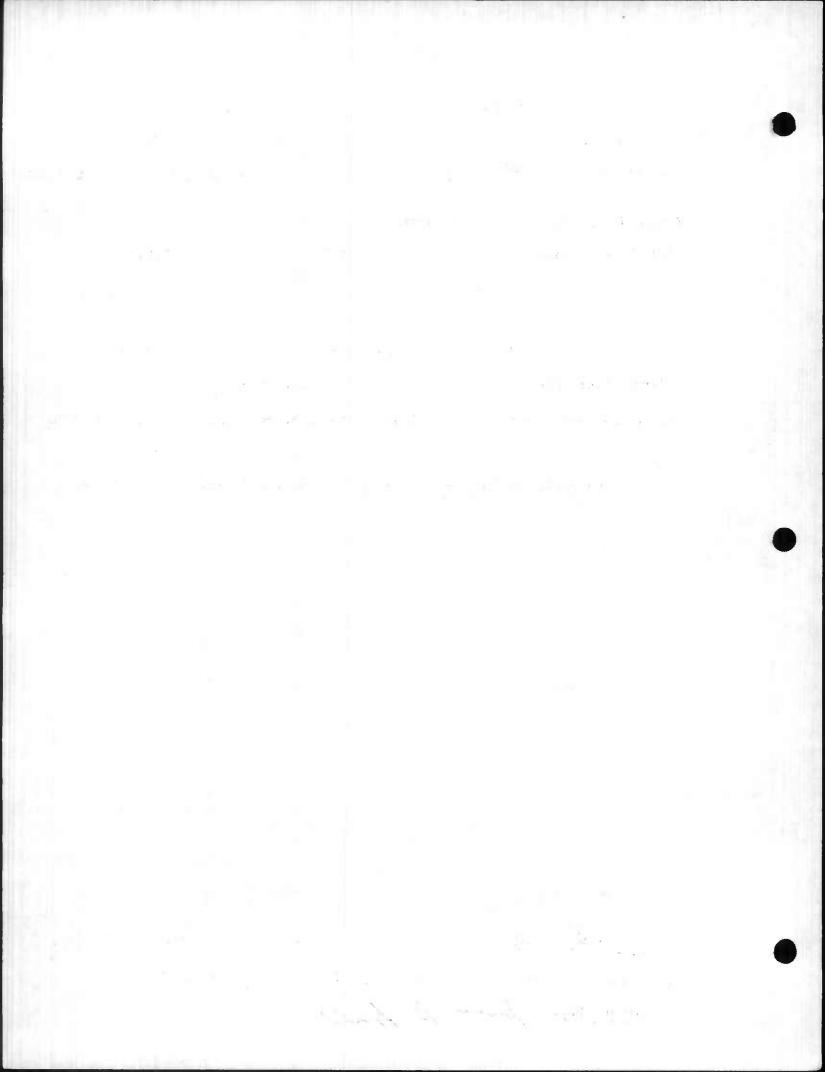
State of Maryland / Department of Health and Mental Hygiene Q Q

А	MENE	#2 PER PHYS.G774 8-3-9 1. Decedant's Nama (First, Middle, La:			Cei	rtificate o	f Death	2. Data of D	Reg. No.	9 2	0000
Physic				7. Y. C. T. A.					TUDY DAY	Yaar	3. Time of Death
/Med Exami		JOHN ANTHON 4a. Facility Nama (If not institution, give					4b. City, Town, o	or Location of Des	26	v of Death	11121
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Funera		5. Social Sacurity Number 6. S	ax 7. Ag		lest birthdey)	If Undar 1 Ya	ar If Undar 24 H	rs. 8. Data of B	HAR		aca (Stata or Foreign
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r 28a-f show	cto	MD BALTIMOR	E		KINGSV:	ILLE					1 ☐ Yas 2 No
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ler des Neme	Ę.	11. Maritai Status 1 ☐ Navar Married 2 ☑ Married	12. Was Decedant Armed Forcas?	Evarin U	1,5.	Yas, specify C	f Hispanic Origin? uban, Maxican, Pu	(Specify Yas or Narto Rican, atc.)	Bla	ce - Amarica ick, Whita, at	
urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 X Yas 2 ☐ I If Yas, Giva Yaar or Datas:	WW	II	1□Yas 2∏XN	lo Specify:		Specia	WHI	TE
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d be filed what Hyg and other	Be C						-			11.0)	
Maryland d 2 should be file th and Mental Hy 7 is merked othe traumetic event	10	ANTHONY SLECHTA 19a. Informant's Name/Relationship (1)	ype, Print)		19b. Mailir	ng Addrass (Stre	JUSEP net end Number or	HINE BL		, Stete, Zip (Code)
		HELEN E. SLECHTA	/ WIFE		- Edward	OMEGA C		NGSVILLE			
S - 2 0		20a. Method of Disposition		20b. F	Piaca of Dispo	sition (Nama of natory or other p		Data	20c. Location		m, Stata
Page nent o nert: If		1. Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State			EART OF	-	7/30/99	RALTIMO	DRE M	D
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Physician /Medical Examiner	er	immediata Ceusa (Final disaasa or condition rasulting in daath)	a. Massi		Intra or as a consac		rral H.	emorrh	nge		12 Hours
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be executed ician and bunal-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury								į	
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necords, P.O. box he law requires that the death cer shas been signed by the attendir tge 2 should be detached for use	Completed by Physician/N	Emphysema. A Peripheral Vas	cular &	n Car	Marien	1601		24a. Wa	s an autopsy formed?	aval	a autopsy findings labia prior to
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Attanding F or death. ector: After by the funer	tlor	1 Vatural 5 Panding invastigation	(Month, De	y Year)	injury	V	Vork? □Yas 2□No		,,		
To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical Certification:	3 Sulcida 6 Could not be datarmined	28a. Place of injuding, ato	ury - At h	oma, farm, str y)	aat, factory, offic	ie :		(Street and Num own, State)	ber or Rural	Routa Number,
Hospil 24 hour Funera	dical	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	raician: To the best of inar: On the basis of	axamina	wiedga, daath	occurred at the vastigation, in m	tima, data and pia y opinion, daath oc	ce, and dua to the curred at the time	a causa(s) and m	annar as sta	ited. Iha cause(s)
ithin (Mec	29b. Signature and tiff of certiflar	and mannar sta	atad.		29c. Lies	ansa number		29d. Data sign	ed (Month. D	lay, Year)
F3F8		· Brew	> B.DI	PLYE	KL M		18424		J414 -		
		30. Name and address of person who of B.D. PAREKHI					FALLS	TON M	no. 210	147	
St	ate	31. Data filed (Month, Day, Year)	32 Ragistr			1					

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State of Maryland / Department of Health and Mental Hygiene Q Q

				State of Ivia	arylariu / i	Certificat			Meritarriy	Reg. No.	2 23	910	
			1. Decedent's Name (First, Middle, La	st)					2. Dete of De	eeth		3. Time of Death	
	Physici		Jeanette P	ToBey	/				Month	25	99	18	
	/Medi Examir		4e. Facility Name (If not Institution, giv					4b. City, Town, or					
			FAIRHAULD					Sykesui	ile	CAR	ROLL		
_	Funeral		5. Sociel Security Number 6. 5		(In yrs. last bii		r 1 Yeer	if Under 24 Hrs	8. Dete of Bi		9. Birthplece	e (State or Foreign	
E	Director		152-05-0150 Usual Residence of Decedent	I	90	Yrs. Months	Deys	Hours Min.	9-2-	-05	Country)	WISCONS	
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								0.7		10g. Citizen of 1			
	e 23	era	7200 Third Avenu		iver in It C	12 Mac Door	217		\\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\	U.S.		ladiaa	
21215-0020	De filed within 72 hours after death with the Maryland stal thygiene. did other than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Meritel Stetus 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorcad	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Control of It Yes 2 ☑ N			to Rican, etc.)		e - American ck, White, etc. y: Whit		
2-0	72 ho	ted	15. Decedent's E	ducetion	16a	Decedent's Usu	el Occur	pation	4.7-	16b. Kind of B	usiness/indusi	lry	
21	hin 7	Completed	(Specify only highest gra Elementary/Secondery (0-12)	College (1-4or 5-	4)	life. DO NOT u	f work done during most of working IT use retired)				,		
2	d wil	NO.	, , , , , , , , , , , , , , , , , , , ,	4	.,	Housewife				Own	Home		
pu	e filed withing the Hygiene.	Be	17. Father's Name (First, Middle, Last,)				18. Mother's Na	me (First, Middle	, Maiden Surnan	ne)		
/lai	should be nd Mental marked o metic eve	To	Herman Henry Pi	.1tz				Ella Za	hn				
Maryland	S D E F		19a. Informant's Name/Relationship (a. Informant's Name/Relationship (Type, Print)					urai Route Numb	er, City or Town,	State, Zip Co	de)	
	alth a 27 is		Nancy Courtney/d	aughter	14	609 Dee	rhur	st Terra	ce, Sil	ver Spri	ng, MD	20906	
Baltimore,	80= 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Piece o cemete	f Disposition (Na ry, crematory or o	me of other pia	ce)	Dete	20c. Location	City or Town,	Stete	
tin	trant tant		4 X Donation 5 ☐ Other (Specif										
Ba	permit. Pa Departmen Important: eny injury		21. Signeture of Funeral Service Licer Joseph B	Van Sant	ent		Ana	tomy Boa MD 21	rd, 655 201	W. Balt	imore	Street	
			23a. Part Enter the disease, or com shock, or heart fallure. List only	pilcetions that caused	the death. Do					errest,	Ap	proximete arvai Between	
9	Physician		,	_								nset and Death	
М	/Medical		immediate Cause (Final disease or condition	Pne	umo	nia					2	Weeks	
U	Examiner		resulting in death)			consequance of):							
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	tificate be executed g physician and es the buriel-transit	edical Examiner	Sequentially list conditions,	Due to (or es a consequence of):									
Ö,	e exe ian a uriel-	ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.							į			
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Box	eath cer attendin I for use	an	•	d									
	The law requires that the death certate has been signed by the attending page 2 should be detached for use	Physician/N	Part II. Other significant conditions of	ontributing to death but	t not resulting l	n the underlying o	euse giv	ven in Part I.	23b. Did tobacco use contribute to the cause of death				
P. O.	by the	h,	Carana	La . 1 .					10	Yes 2000	3 Probab	ly 4 Unknown	
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>	cert	o Be	examiner?	Hospital: 1 ☐ Inpatien			Oth	nor .	ath (Check only				
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on	ding h. Afte	tlor	1) Natural 5 Pending invastigation	(Month, Day		njury M	28c. Injui Woi 1 □	rk? Yas 2∐ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	17.		
S	Attending Physician: ar death. ector: After this certific by the funeral director,	Certification:	3 Suicide 8 Could not b		ry - At home, fa				28f Location	Street and Numb	per or Rural Re	oute Number	
\leq	after Direct	ert	4 ☐ Homicide determined	fectory, offica 28f. Location (Street and Number or Rural Route Number, City or Town, State)			33.0.743.77207,						
	ours erai	-	29a. Certifier 12Certifying Ph	veloien: To the best of	l my knowledes	donth provinced	at the tir	me, date and place	and due to the	cause(s) and m	noner en etate	d	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		ysician: To the best of niner: On the basis of end menner stat	examination an	d/or investigation	, in my c	ppinion, death occi	irred at the time.	date and place,	and due to the	ceuse(s)	
	ithin o the	M	29b. Signeture and title of certifier	Control of all		29	c. Licens	se number		29d. Dete signe	d (Month. Day	, Year)	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** JANET THOMPSON July 20, 1999 21:37 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City Sinai Hospital of Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 3-19-24 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 20 F Months 75 Yrs Director 220-22-6683 MD. Uaual Residence of Decedent death with the Manyand 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits ahom r than "natural", or items 23a or 28a-f ahor the Madical Examiner must be notified at L Yes 2 No Directo MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5507 WINTON AVE. 21207 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Specify: BLACK 1 Yes 2 No Specify: If Yes, Give Year or Dates: à 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementary/Secondary (0-12) College (1-4or 5+) -12--0-HOUSEWIFE DOMESTIC permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If hem 27 is marked other? 17. Father's Name (First, Middle, Last) 18 Mother's Neme (First Middle, Maiden Sumame) Be CLEO LEE LILLIAN BAILEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) CLAUDIA SOLLERS (DAUGHTER) 5507 WINTON AVE. BALTIMORE, MARYLAND 21207 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 1 XBurial 2 Cremation 3 Removal from State LOUDON PARK CEMETERY 7-27-99 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service License 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Tol 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final Myocardial Infarction disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of 8 Physician/Medicai Due to (or as a consequence of) 8 950 Pol ed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? signed by d 1 Yes 2 No 3 Probably 4 Unknown Hypertension P 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed Coronary Artery Disease peen completion of cause of death? has 1 Yes 28 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1□ Yes 2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 Accident death. 1 Yea 2 No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical

Box 68760, P.0. Records, Division of Vital after death 24 hours a Funeral D To the Hosp within 24 hos To the Fune completely fi

nown HS.

State Registrar

(Check only one)

29b. Signature and title of certifie

Tariq Khan, M.D. 31. Date filed (Mongy, Pay, Year) 32. Registrar's Signature 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Uneva p. 1.90 // 2

Sinai Hospital of Baltimore, 2401 W. Belvedere Ave. Balto.Md

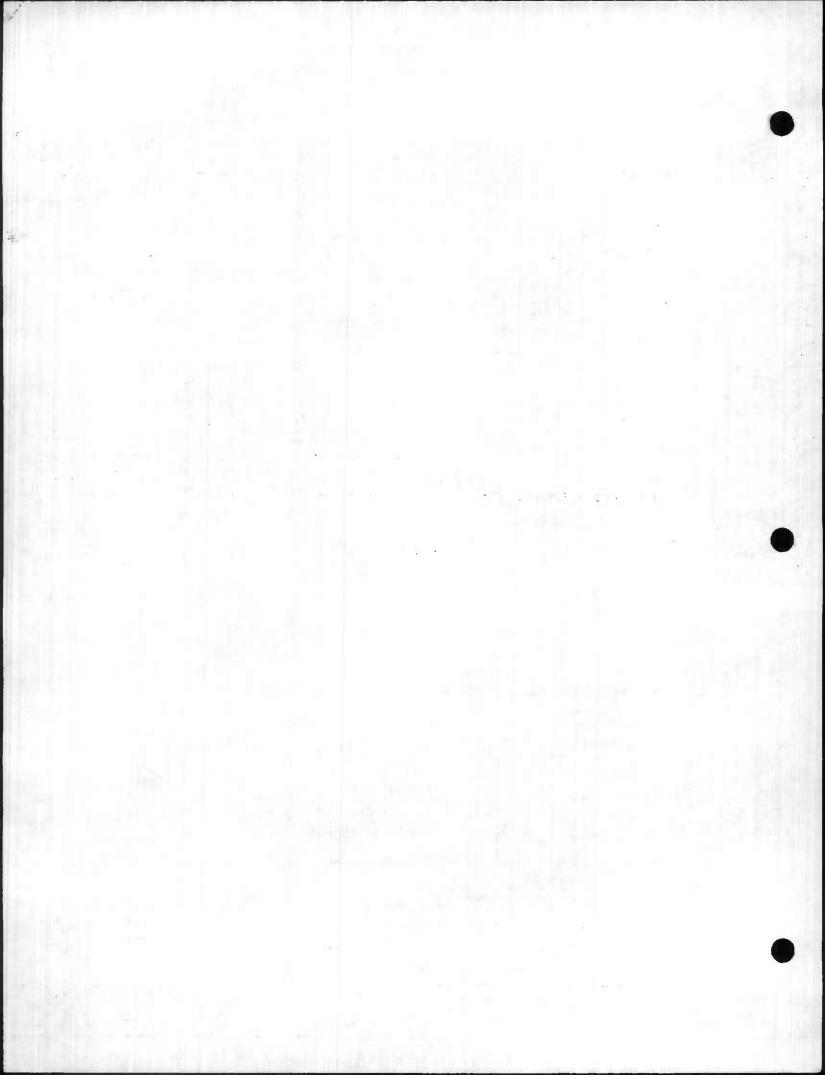
21215

29d. Date signed (Month, Day, Year) 7/21/1999

ORIGINAL

29c. License number

D0021730



WILSON, RONALD Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 23912 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 15 pm **Physician** WILSON ONALD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner BALTIMORE
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
MAY 12, 1962 NIA MERC HOSPICE If Under 1 Yaar Birthplaca (Stata or Foraign Country) 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Months Days 242-84-0294 Yrs. Director Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumstic event, the Medical Examines must be notified at 1. Yes 2□No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4824 MER 12 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic evene. Funeral 12. Was Dacedant Evar in U,S. Armad Forcas? 1 X Yes 2 □ No If Yes, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian 11 Marital Status Black, White, atc. 1 Naver Married 2 Married altimore, Maryland 21215-0020 1□ Yes 200No Specify: Specify: à BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) College (1-4or 5+) Elamentary/Secondary (0-12) MAN HOUSING AUTHORIT MAINTENANCE UNKNOWN 18. Mother's Nama (First, Middla, Maldan Surnama) 17. Father's Name (First, Middla, Last) Be ALFRED WILSON WHITE To 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. tntormant's Name/Relationship (Type, Print) 824 ROSA WHITE AVENUE BALTIMORE, MO. 2/2/5

20c. Location - City or Town, State MOTHER MER 20b. Place of Disposition (Nama of cematary, cramatory or other placa) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shipck, or heart tailure. List only one cause on each line. the second of resolution of the second of th UNERAL HOME BALTO, MD. 2121 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical noma Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate causa. Entar Undarfying Cause (Disease or Injury that Initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence ot) P.O. Box 68760 Physician/Medical Dua to (or as a consequence ot) 88 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, g 24b. Ware autopsy tindings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2000 28. Place of Death (Check only one) Stella MARIS at MERW or Attending Physician: 25. Was case reterred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of tnjury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 5 Pending Investigation 1 Netural 2 Accident after death. 1 Yes 2 🗆 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28t. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homlcide 24 hours a Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. within 2 To the 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of cartifiar 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 30, StPaul Place Bultimore MD

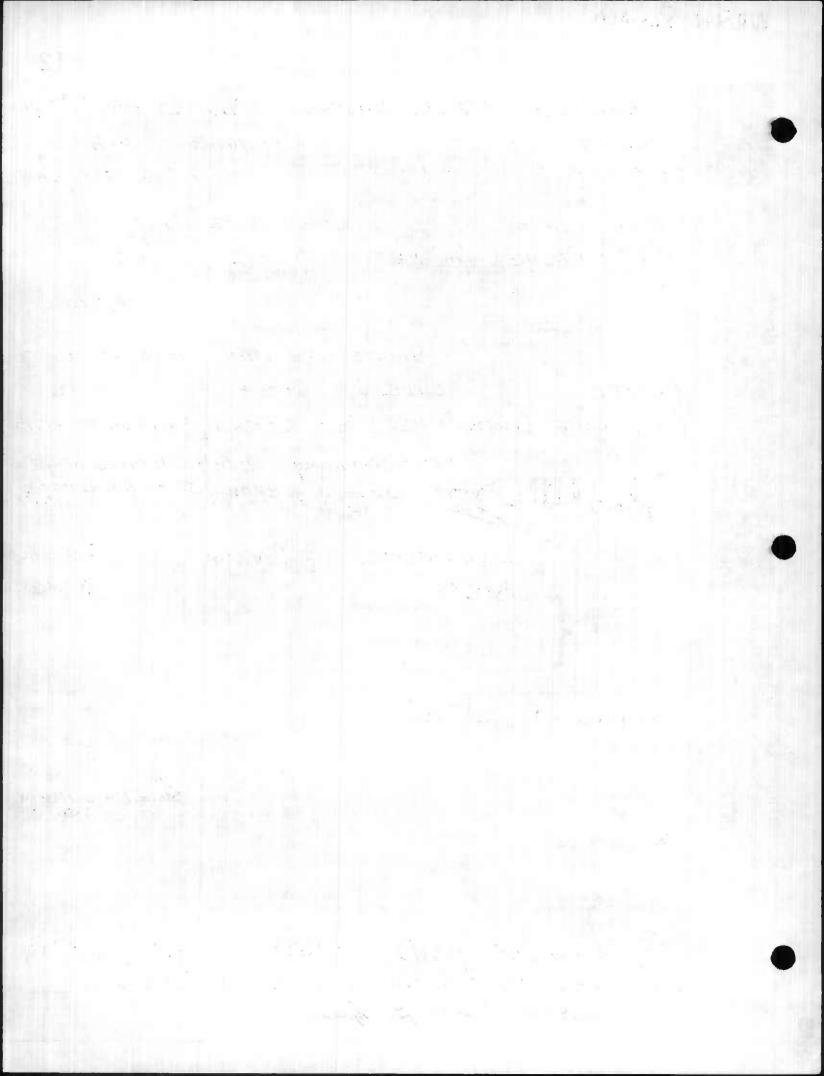
32. Registrar's Signature

1999

\$ 550

State

Registrar



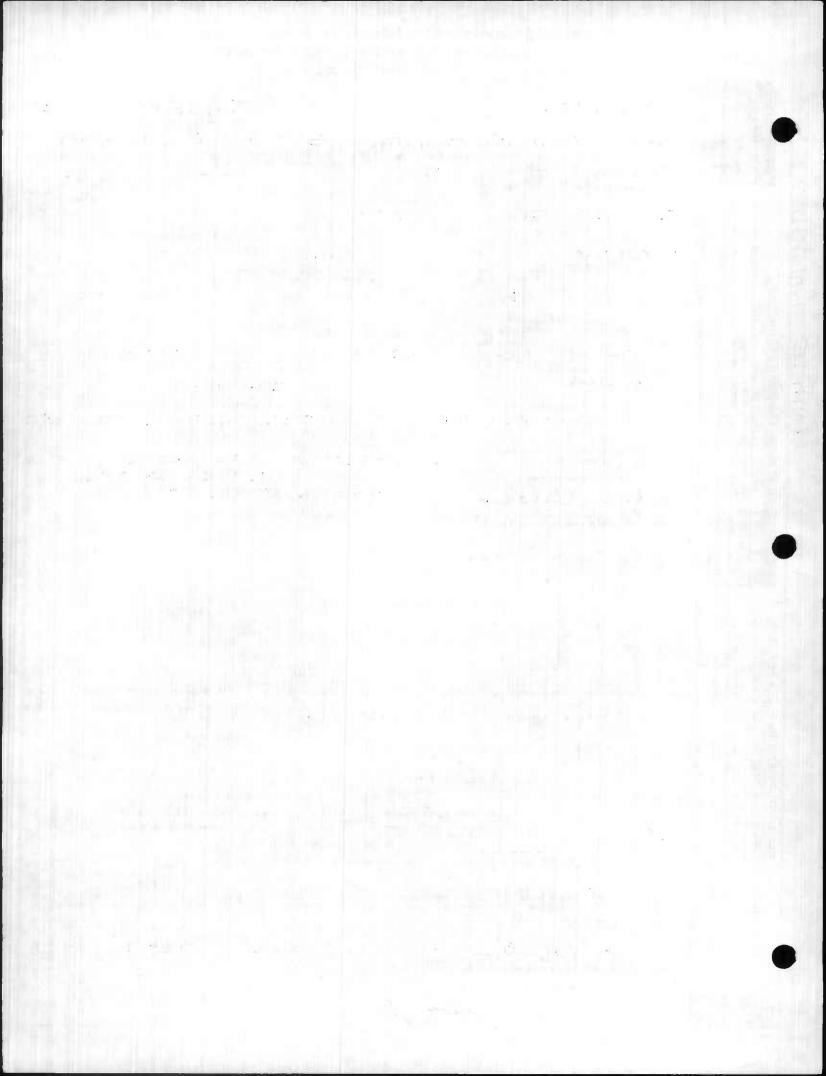
WHITE ROLAND O.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death **Physician** 25,1999 3:23pm ROLAND D. WHITE JUN /Medical 4a Escility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GIEN BURNIE ACOUNTY ARUNDEL If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 F Months Days 213-19-8239 78 MD. Director Usuat Rasidance of Decedant 72 hours efter death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 and 2 should be filed within 72 hours efter death with the Manylar Health and Mental Hygiene. em 27 is marked other than "natural", or fleme 23a or 28a-f show wither traumatic event, the Modital Exercise main be notified as MD. ANNE ARUNDEL SEVERNA PARK 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 84 HOYLE LANE 21146 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ⊠ Yas 2 □ No If Xas, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Rsca - Amarican Indian. 11 Marital Status Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: Specify: BLACK by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) -10--0-ENGINEER NAVAL ACADEMY 18. Mothar's Nama (First, Middla, Maidan Surname) 17. Fathar's Nama (First, Middla, Last) Peges 1 and 2 should be 1 nent of Health and Mental 8 ARTHUR WHITE CARRIE WATTS 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) LINDA WHITE-ANDREWS (DAUGHTER) 3805 CIELO VISTA CT. MITCHELLVILLE, MARYLAND 20721 20b. Place of Disposition (Nama of cematary, cramatory or othar place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Department of Important: If it any injury or o 1X Buriai 2 ☐ Cremation 3 ☐ Ramoval from Stata 7-29-99 CROWNSVILLE, MARYLAND MD. VETERANS CEMETERY 4 Donation 5 Other (Specify) 21. Signature of Punaral Sarvice Lissaa 22. Nama and Addrass of Facility WM. REESE & SONS MORTUARY 821 WEST ST. ANNAPOLIS, MARYLAND 21401 gese her the dise se, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, r haart failur. List only one cause on each line. Approximata Intarvsi Batween Onsat and Death **Physician** /Medical Immediata Causa (Final PNEUMONIA disaasa or condition rasulting in daath) Examiner Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if sny, taading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequance of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by the 1 Yee 2 No 3 Probably 4 € Unknown CONGESTIVE HEMMI Division of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? been si DIABETES 24a. Was an autopsy Completed certificate has OLD STROKE 1 Yas 2 No 1 Yas 2 No or Attending Physician: 25. Was casa rafarrad to medicat axaminar? Be 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Lo 1 | Inpatiant 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No death. Invastigation Director: / 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) hin 24 hours aft the Funeral Di npletely filled in 1 Certifying Phyelctan: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the To the Comple 29b. Signatura end titla of cartifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number 21776 30, Nama and eddrass of person who complated ceusa of death (Item 23a) (Type, Print) HANNER SK BALTIMORE SURYA 3001 My MUNTRA 32. Ragistrar's Signatura 31. Data filed (Month, Day, Yaar)

DHMH 16 Rev 6/95

Registrar

JUL 29 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day 1999 Month Inez Milligan Washington 19 3PM July 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Prince Georges 8. Data of Birth (Month, Day, Year) If Under 24 Hrs. 5. Social Sacurity Number If Under 1 Year Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Days Hours 1□M 2/2 F 578-14-8637 87 Jan 12 1912 Sumter S.C. Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits West 1 Yas 2 No Prince Georges Hyattsville 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20789 United States 1413 Madison 12. Was Decedent Evar in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Yes 2 No If Yas, Give Yaar or Datas: 1 Nevar Married 2 Married 1□ Yes &G-No Specify: Specify: Black 3℃ Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. Do NOT use retired).
Retired Seamstree Seamstress/Retired 15. Decedent's Education (Specify only highast grade completed) 2vears Elementary/Secondary (0-12) Clothing 17. Father's Nama (First, Middla, Last) 18. Mother'a Name (First, Middle, Maiden Surname) Naomi M. Davis Milligan Unaviable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice Washington 1413 Madison Street, West Hyattsville, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata Date cemetery, crematory or other place) ▼Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Ft. Lincoln 7/23/99 Bladgenburg MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Washington, D. C. 20011 CCO348 Latney's 3831 Georgia Avenue, N. W. 23a. Part1. Enter the disease, or composations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Cause (Final 1060 1 OWER diseasa or condition resulting in death) Dua to (or as a consequence of) Sequantially list conditions, if any, laading to immediata cause. Entar Undarfying Cause (Disease or injury that initiated evants rasulting in death) Last ORONAR RIER Due to (or as a consequence of): IEC IROL 1/0 Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Pinpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Md.

item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic avent, ma Medical Examiner munt be notified at

filed within 72 hours efter Hygiene. other than "natural", or its

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygid Important: If Item 27 is marked other: any Injury or other treumatic avent.

altimore, Maryland 21215-0020

"natural", or Items 23s

physician and s the burial-transit be executed Box 68760. for use as USB 85 P.O. 5 signed t Records, Dee0 page 2 Division of Vital

Physician/Medical

þ

Completed

8

Certification: To

Medicai

certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

DHMH 16 Ray 6/95

Registrar

31. Data filed (Month, Day, Year) JUL 2 9 1999

29b. Signature and title of certifie

1 (Matural

2 Accidant

3 Suicide

29a. Certifian (Check only one)

4 Homicide

5 Panding invastigation

6 Could not be datamined

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 ☐ Yas 2 ☐ No

29d. Plata signed (Month, Day, Year)

KORD JUITE 380 LAUREL, NO 20707

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

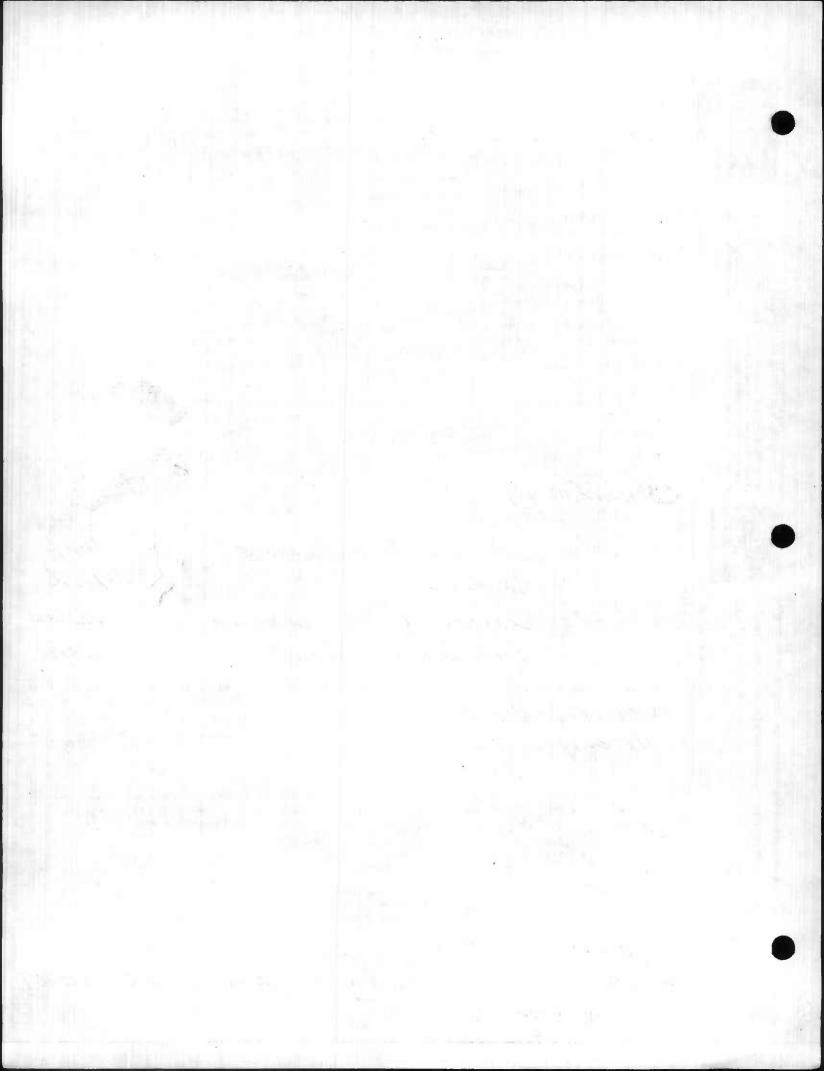
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

170 32. Registrar's Signatura

000

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Leo C. Washenfeldt, Jr. July 25, 1999 4:50 pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1378 Old Water Oak Point Road Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 10√M 2□ F Months Deys Hours Min. 217-24-1043 Yrs. 70 Director Baltimore, MD Uaual Residence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Examiner must be notified at MD Anne Arundel Pasadena 1 X Yas 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò Лета 23а 1378 Old Water Oak Point Road 21122 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Introctant: if Item 27 is marked other than "natural", or hen any injury or other traumatic avant, the Health and Pages. Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 X No Specify: Specify white py 3 ☐ Widowed 4 👿 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer Pavsner Press 11 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Leo C. Washenfeldt, Sr. Marie C. Thornton 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kay Heath / Daughter 2042 Kurtz Avenue, Pasadena, MD 21122 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) New Cathedral Cem. 7/28/99 Baltimore, MD 21. Signature of Funeral Service U 22. Neme end Address of Facility Loudon Park Funeral Home, 3620 Wilkens Avenue Baltimore, MD 21229 Fert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examine The law requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the causa of death? signed by t 1 Yaa 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat axeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Affer Attending 1 Matural 5 Pending investigation n 24 hours after death.

• Funeral Director: After the function of the functin 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 8 Hospital Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) To the F To the F complet 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Benjamin 7109 Jumper Hole Road, Severn Park, Maryland 31. Dete filed (MOST), Day, See 1999 32 Registrer's Signeture

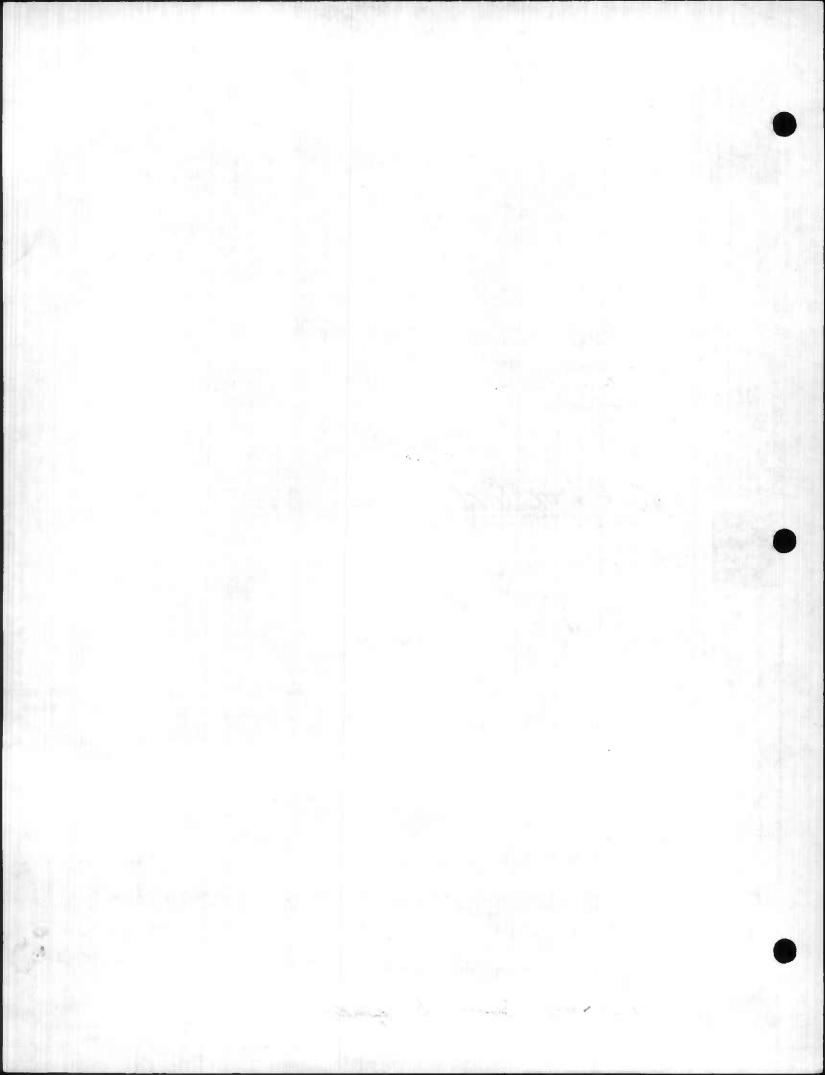
DHMH 16 Rav 6/95

State Registrar

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760.

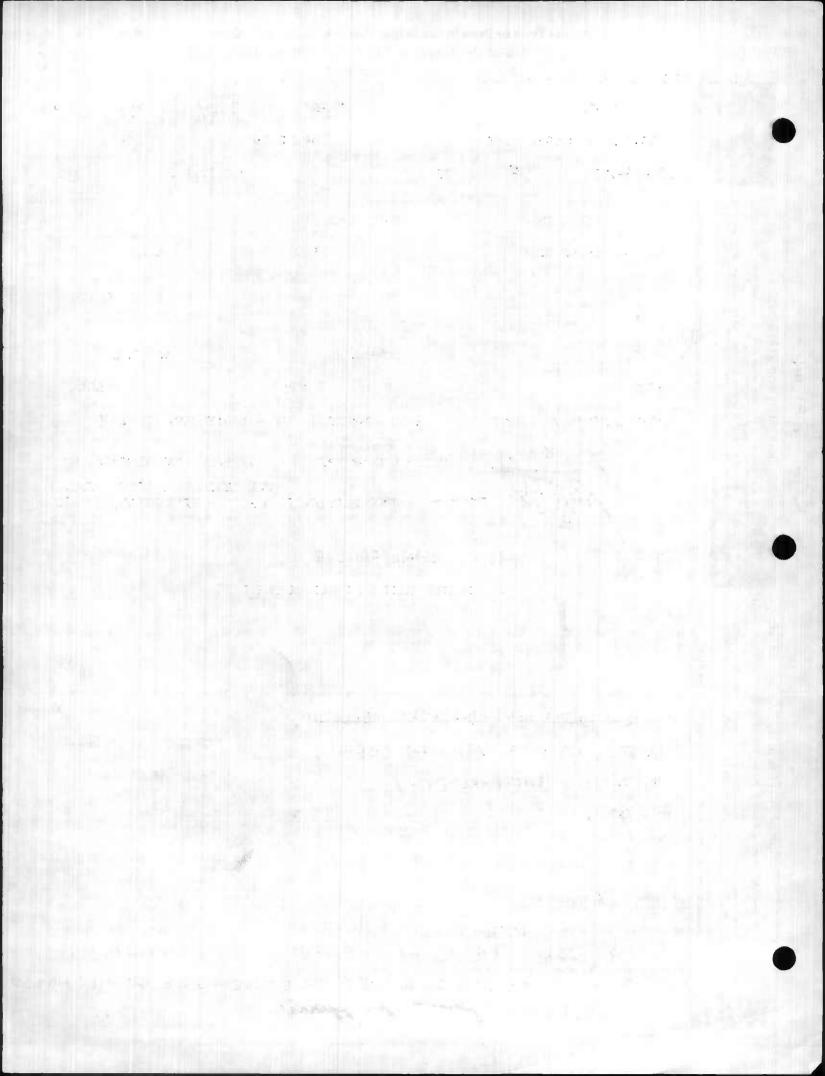
Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

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Donation 5 Conner (Specify) WELLWOOD CEMETERY 7/25/99 FARMINGDALE, N. 22. Name and Address of Fecility SOL LEVINSON & BROS., INC 8900 REISTERSTOWN ROAD — PIKESVILLE, MD 2. 23. Pert I. Einer 8th disease for amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Physician Medical Examiner The square of the squar										de)
Physician Madical Examiner 23a. Port I. Enter the desease promptications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a special control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Both the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Both the deeth. Do	nore, ages 1 el not of Hear 1: If item 5 y or other	1 Burial 2 Cremetion 3	Removel from Stete	cemetery, cres	natory or other pla					
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Physician / Medical Examiner Medical Examiner	THE RESERVE	23a. Pert1. Enter the disease, or comp	plicetions that caused the						. Apr	proximate
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29d. Dete signed (Month, Day, Year	Hospital 24 hours a Funeral E ptaly filled	(Check only 2 Medical Exam	iner: On the basis of exa	aminetion end/or in	occurred et the ti	me, dete end plece, opinion, deeth occur	end due to the red at the time,	ceuse(s) end me dete and piece,	enner as stated and due to the	d. cause(s)
	o the omple				29c. Licen	se number		29d. Dete signe	d (Month, Day	, Year)
17310171	F S F S	SE167			Do	5610		JULY .	23 10	199
30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print)		30. Nema and address of person who				- 010		(-3. '	

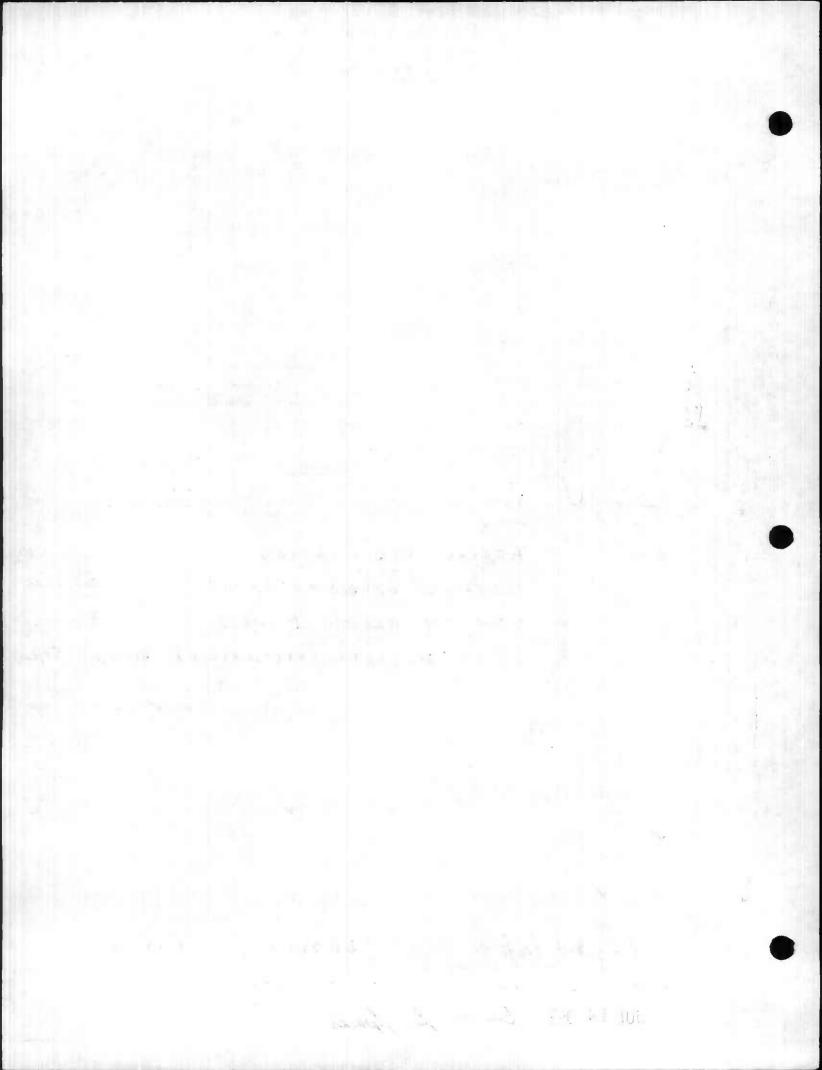
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State of Maryland / Department of Health and Mental Hygiene Q Q 22017

					Certifica	te of		R.	eg. No.	, 4	3911
	Dhusisian	1. Decedent's Name (First, Middle, L	ast)					2. Date of Deal Month	h Day	Year	3. Time of Death
	Physician /Medical	Dowothy Edith 20	ches					July 13		1001	1310
	Examiner	de Casilla Mana Mana Institution -	ive street and number)			4	lb. City, Town, or I	ocation of Death	4c. County	of Death	
		Sunrise Care and					Elkton		Cec		
	Funeral Director	140-24-2689	Sex 1 □ M 2 (□ F	(In yrs. last birt	rs. If Under	Days	Hours Min. Sept	8. Date of Birth (Month, Day, tember 2	Year)	9. Birthpla Country New Je	ce (State or Foreign y) ersey
	pu B	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					100	d. Inside City Limits
	denyt reho			•							1⊠Yas 2□No
	vith the Me or 28a-f a be notthed	Maryland Cecil 10e. Street and Number		Elkto		ip Code		1	0g. Citizen of V	Vhat Countr	v?
	New ith		e Apartment	a unit			921				
	fler death with the Merylar r hems 23a or 28a-f show yost must be notified at Funeral Director	11. Merital Stetus	12. Was Decedent Ex				ispanic Origin? (Sp in, Mexican, Puert	pecify Yes or No-		e - American	n indian,
21215-0020	or af	3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 Mo If Yes, Give Yeer or Detes:		if Yes, sp 1 ☐ Yes		Specify:	o Hican, etc.)	Specify	k, White, at Whi	ite
2-0	"natural",	15. Decedent's 1	Education	16a.	Decedent's Us	uat Occup	ation	tina	16b. Kind of Bu	siness/indu	stry
21	9 13	(Specify only highest g	College (1-4or 5+		life. DO NOT	use retired	during most of wor	King			
	Hygiene. ther than ont, tre	12			omemake	r			in her		ome
pu	215E	17. Father's Name (First, Middle, Las					18. Mother's Nan	ne (First, Middle, I	Vaiden Surnam	e)	
yla	Men Men To To To To To To To To To To To To To		rvin				Eliza	abeth A.	Chambe:	rs	
Maryland	2 should and he is many reumer	19a. Informant's Name/Relationship					and Number or Ru				
	Heelth Heelth Fm 27 ther tr	Steven E. Arches	/ son	18	04 Hambi Disposition (Na	urg A	venue, Eg				sey 08215
Baltimore,	ages ant of t: if its y or o	20a. Method of Disposition 1 Description 3 4 Donation 5 Other (Special Control of the Control		Gilpin	y, crematory or Manor al Park	other plac	28)	7/16/99	Elkto		
alt	Departme Departme Importan any injur	21. Signature of Funeral Service Lice	ensee				ss of Facility				
ш	70F # 9	1 Daniel.	& Huls	\supset			for Fune	William Control of the Control of th			4 21021
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused to	he death. Do n	ot enter the mo	de of dyin	g, such es cardiec	or respiratory arm	est,	. /	Approximete ntarval Between
	Physician	orion, or regar tanoro. Electric	y one cause on baon mile								Onset end Death
14	/Medical Examiner	Immediate Causa (Final disease or condition	ATRI	AL 1	FIBRI	LUA	TION				C wenter
		resulting in death)		ue to (or as a c							
	executed in and tel-transit		15CUT	mic	CHR	000	MYOPA	+ THY			2 years
	and Fran	Sequentially list conditions, it any, leading to immediate	D	ue to (or as a c	onsequence of):					
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68760,	tificate be executed g physician and as the burial-transit fedical Examir	resulting in death) Last		ue to (or as a co					~	i	10
			d ANUER	UDSCL	-EROT	110	CARDIO	UKSCLER	tu Dl	SEASE	J year
Вох	igned by the attending be detached for use a by Physician/M										
0	y the checked	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying	cause giv	en in Part i.				the cause of death?
0	es that igned b be dete							1 4	aa 2D No	3 Probe	ibly 4 🗆 Unknown
Records,	seen s hould							24a. Was a perform		com	e autopsy findings lable prior to pletion of cause
Re	sician: The law certificata has birector, paga 2 s							4574	· and		eath?
tal	in in in in in in in in in in in in in i	25. Was case referred to medical	1				OC Diseased Date	th (Check only on	93 ZLIPNU	10	Yes 2DHNo
of Vital	Physician: ribis certific ral director,	examiner?	Hospital:	t 2 EP/Out	tpatient 3 D	Oth Oth	-	ome 5 Reside		or (Consit.)	
0	Physerthis eral d		28a. Date of Injury	28b. T	ima of	28c. tnjur Wor		28d. Dascribe ho			
ion	Attending I or death. ector: After by the funer iffication	1 DNatural 5 Pending 2 Accident investigation	(Month, Day	rear) in	njury M		Yes 2 □ No				
Division	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could not determine	be 28e. Place of Injur building, etc.	y - At home, far (Specify)	rm, str <i>ee</i> t, facto	ry, office		28f. Location (SI City or Town	reet and Numb n, State)	er or Rural	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7		hysician: To the best of minar: On the basis of a end menner state	xamination and	death occurred For Investigation	d at the tin n, in my o	na, date and place pinion, death occu	, and due to the corred at the time, d	ause(s) and ma ate and place,	nner as sta and due to t	ted. he cause(s)
	Within To the comp				25	c. Licens	e number	2	9d. Date signe	d (Month, D	ay, Year)
		1 Film In	lund			0 0	7463		7-18.	-99	
	5	30. Nama and address of person who	completed cause of dea	ath (Item 23a) (- /	
		Rolando A. Najer				Stre	et, Elkto	on, Mary	land 21	921	
	State	31. Date filed (Month, Day, Year)	32. Registrar								

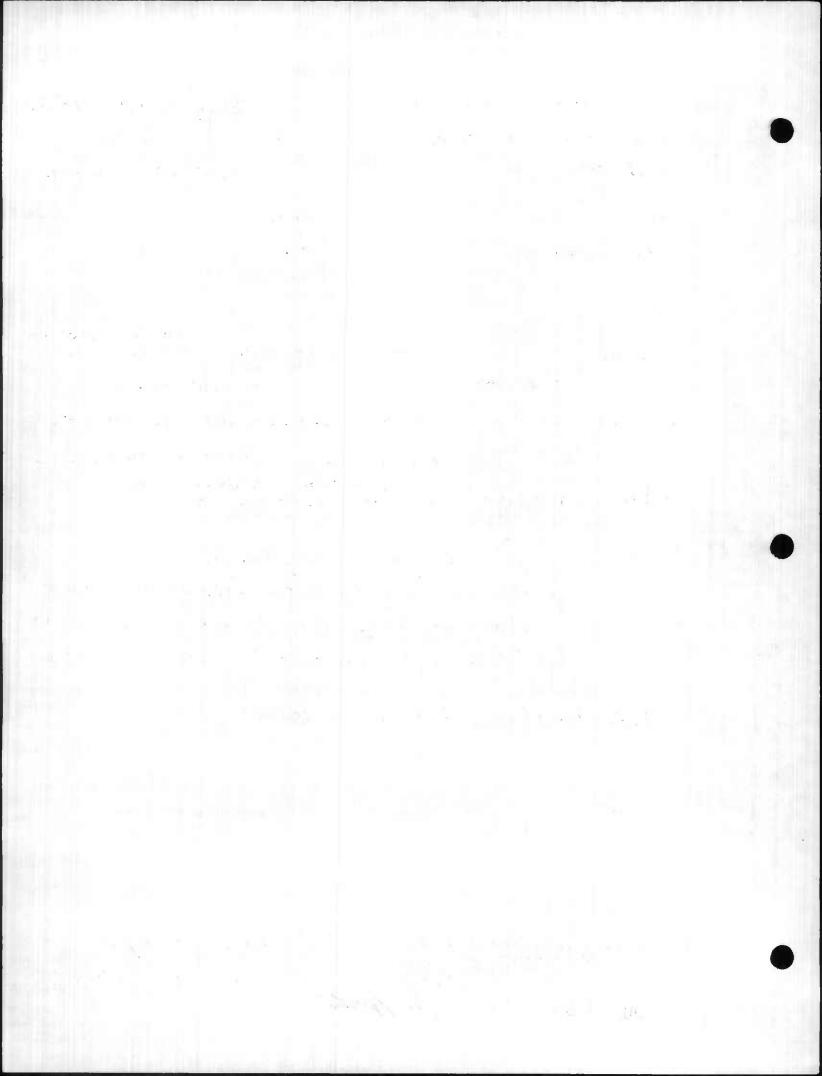
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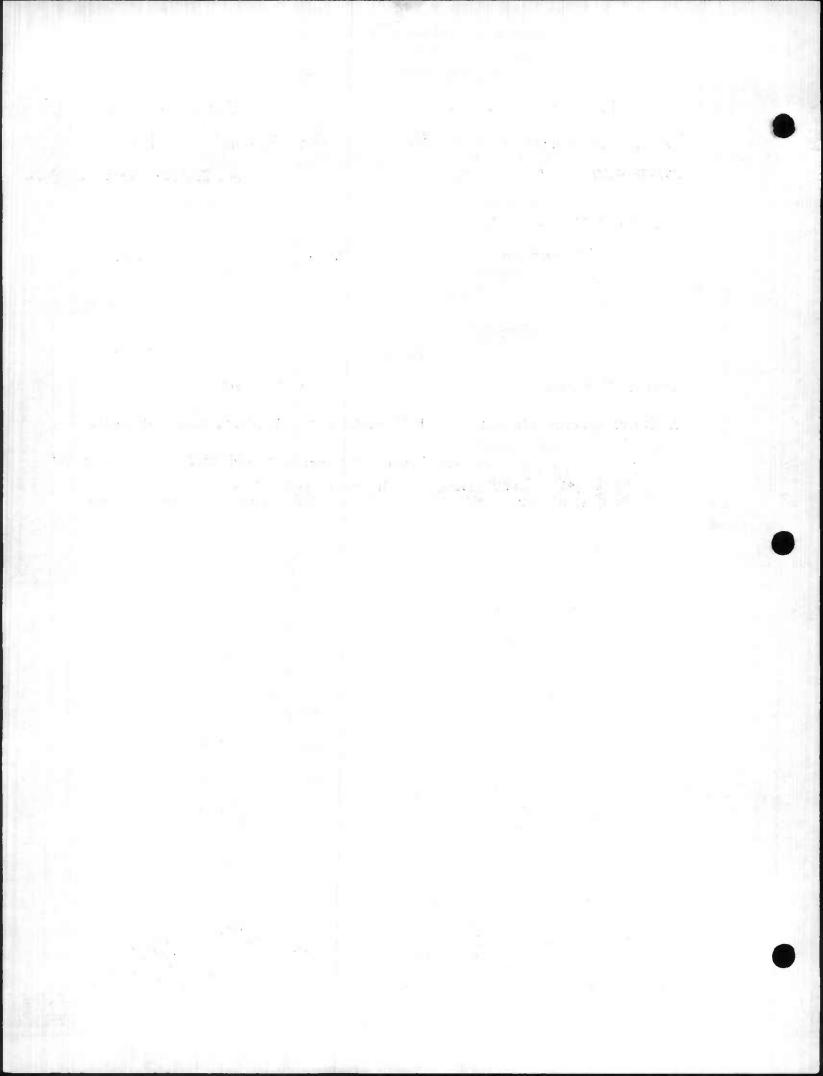
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п	Physici /Modic		Ett	a Matthews	Lofth	ouse	Andre	ews			JULY JULY	Day	1999	153D	
	/Medic Examin		4a Facility Nama (If not institution	, giva street and number	r)				4b. City, To	wn, or Lo	cation of Death	4c. Coun	ty of Death		
			Union Hospita	1 of Cecil	Count	У			E	1kto	n		Cec	il	
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	he M	Director		Cecii			404	Zin Code	EIKU	011		10g. Citizen o	S Martin Court		-
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	and and a saith n 27		Joseph L. Lofth	ouse (son)						rive	, Elkton				
ore	Pages 1 lent of H mt: If iten rry or oth		20a. Method of Disposition #☑Buriai 2 ☐ Cramation	3 □Ramovat from State	20b. P	iace of D amatary,	Disposition (A cramatory o	vama of or othar pla	ce)	1	Data	20c. Location	ı - City or To	own, Stata	
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Baltimore	permit. Pa Departmen Important: any Injury		21. Signuture of Funaral Sarvice I	Licensee			Lee A	and Addra	ss of Facili	on &	Son Fu	neral H	lome		
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1	/Medicai Examiner		Immediata Causa (Final disaasa or condition rasulting in daath)	a. Atcu	rte	1	uln		wy	Im	hus			1600	
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,	exect n and ial-tra	Exa	Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseasa or Injury	Blin	Dua to jo	ras a co	nsaquance c	100		16	0 4			VIONE	
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Division	Attending or death.	lica	2 Accidant invastig	not be	niury - At ho	oma, tarn				1	28t. Location (S	Street and Nur	nber or Run	al Routa Number,	
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one) 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.												
	Withi To th	Σ	29b. Signatura and titia of certifian	1.11	1,0)		29c. Licans	se number		-	29d. Data sign	ned (Month,	Day, Year)	
			Marino	utilal 1	112	17		W	22	3	0	7/10	5/99		
	3		30. Name and addrass of person	who complated causa of	death (Ten	n 23a) (T	ype, Print)	2.	126		2. 1. 1		1117	and non	
	_		SHIHNTIL	ALK	TA	76	-4	11/10	1001	nex	regit	vere	11/1	17/2/2	1
	Sta Registr		JUL 1 6 19	99 Bulletin	itrar's Signa	1	100	res !							

DHMH 16 Rev 6/95



Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month 5A liam Juli 4a. Fscility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Livingston Health Care If Undar 1 Yeer If Undar 24 Hrs. 8. Bale of Birth Months Deys Hours Min. (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 100 M 2□ F 241-22-9330 91 29,1907 North Carolina Usual Rasidence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural". or harman any injury or other traumatic event. 10b. Count 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Maryland Prince George's Accokeek 10e. Street and Number 10f. Zlp Coda 10g, Citizen of What Country? 703 Manning Road East 20607 U.S.A. 12. Wes Decedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 D No If Yas, Giva Year or Dates: Was Decedant of Hispenic Origin? (Specify Yes or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rsce - American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yas 2 No 3 X Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 17. Fethar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meldan Surneme) William H. Burton Annie Wyatt 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) W. Eleane Stachura/Friend 8555 Ridge Court, Waldorf, Maryland 20b. Place of Disposition (Nama of cemetary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Trinity Memorial Gardens 7-24-1999 Waldorf, Maryland 4 ☐ Donafion 5 ☐ Other (Spegify) 21. Signetur of Func al sarv 22 Nema and Address of Facility
The Huntt Funeral Home M00053 P.O. Box 156, Waldorf, Maryland MARK G. **BROHAWN** mew 23a. Part1. Enter the disesse, or complications thet caused the death. Do not antar the mode of dying, such es cardiec or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in daath) Examiner Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the deeth certificata be associted within £2 khours eight death.

To the Funeral Director Attar this cartificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriet-transit Sequentially list conditions, if sny, lasding to immediata cause. Enter Underlying Csuse (Disaasa or injury that infliated events resulting in death) Last Division of Vital Records, P.O. Box 68760 by Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacceruse contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown 24a. Wes sn autopsy performed? 24b. Ware sutopsy findings eveilable prior to completion of cause of death? Completed 1 Tyas 25. Was case refarred to medical axsminar? 8 26. Pleca of Deeth (Check only ona) Othar: 4 Nursing Home 5 Residance 8 Othar (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Dsta of Injury (Month, Day Year) 28c. Injury st Work? 28d. Describe how Injury occurred 28b. Time of 5 Panding Invastigation 1 Natural 1 Yas 2 🗌 No 2 Accident 6 Could not be datarmined 3 Suicida 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 281. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicida 29a. Certifier 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. MD 29b. Signature and title of certifier Fort Rd. Day, Year) 32. Registrar's Signature State



State of Maryland / Department of Health and Mental Hygiene 99

				,,	Certifica	ate of Death		Reg. No.	5 4	2350
	Physici	an	1. Decedent's Neme (First, Middle, Last	<i>t</i>)			2. Dete of De Month	eth	Vear	3. Time of Deeth
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4	Examir	ner	4e. Fecility Nama (If not institution, give Alice Byrd Tawes N	. 11	201 Hall H Crisfield M		field		of Death 21Set	
Н	Funerai		5. Sociel Security Number 6. Se		last birthday) If Und	dar 1 Year If Undar 24 Hrs	8. Deta of Bir			ice (State or Foreign
	Director		012-14-040	□M 2 X F 7.	3 Yrs. Month	s Deys Hours Min	08- J	5-1925	Counti	MD
	hand ow		Usual Residence of Decedent 10e. Stete 10b. County	10c. Cj	ty. Town or Location				10	d. Inside City Limits
	a-f eh	ctor	$MD \rightarrow c$	merset (_Ris Ho	ld				1XYes 2□No
	or 28	Director	10e. Street and Number	11000 5	10f. 2	Zip Code		10g. Citizen of \	What Countr	y?
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0	after d		1 Navar Married 2 Merried	Armed Forces? 1 ☐ Yas 2 Mo	If Yas, s	bedant of Hispenic Origin? (Specify Cuban, Maxican, Puer	to Ricen, atc.)	Blac	ck, White, et	
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Maryland	should be nd Mentel marked o	To	JAMUE HOI	2Seq	don Malifer Adda	MARI		Johns		
	nd 2 shoulth and 27 is m		ANThony E. W.	RED COUSIN	2111	iss (Street and Number or R	Stield.	UD	State, Zip C	Code)
ore,	ges 1 end 2 should be filed within 72 hours after deeth with the Marylan it of Health and Mentel Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other treumatic event, the Medical Experient result by nortified at		20e. Method of Disposition 1 8 Burlal 2 Cremetion 3 F	20b. F	Plece of Disposition (Accemetery, cramatory of	lame of	Date	204. Location -	City or Tow	n, State
Baltimore,	permit. Pages 1 end Department of Health Important: If Item 27 any Injury or other th		4 ☐ Donetion 5 ☐ Other (Specify)	H	pewell C	emetery	7-10-99	Hopeu	bell	MD
Bal	permit. Pa Departmen Important: any injury pnce.	21	21. Signetura of Funerel Service Licens	00	A. Name	end Address of Pacifity		eral the	mo	
			23a. Pert1. Enter the disease, or corpol shock, or haart feilure. List only or	ications that caused the day	314 C	oue ST. Cris	field	MD 3	4811	Approximate
	Physician		shock, or haart feilure. List only or	ne ceuse on each line.		out of the state o	o or raspiratory or	1001,		nterval Between Onset end Death
	/Medical Examiner		Immediate Ceuse (Finel disease or condition	Metas	static	Colon Car	rcer			
		-e	resulting In deeth)		or es e consequence o	f):				
	outed id ansit	edical Examiner	Sequentially list conditions	0	or es a consequence o	n.				
Ő,	e axec	Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	-	57 00 tz 0011304g01100 0	9,				
68760,	deeth certificate be axecuted e attending physician and od for use as the bunal-transit	dica	that initiated events resulting in death) Last	Due to (c	ir as a consequence of):				
Box (5 50	~	L ,	d						
œ œ	that the deeth ce ed by the attendii detached for use	Physician/	Pert II. Other eignificant conditions con	ntributing to death but not res	ulting in the underlying	ceusa given in Part I.	23b. Dld 1	obacco use co	ntribute to t	he cause of death?
P.O.	The law requires that the ste hes been signed by the pege 2 should be detached.						10	700 20 (No	3 Probe	bly 4 Unknown
ds,	w requires that been signed to should be det	d by					Ode Wee		24h War	a autopsy findings
Records,	w raqu	Completed						en autopsy med?	aveil	eble prior to pletion of cause eath?
	The lay	шо					101	es 200		Yes 2□ No
Division of Vital		Bec	25. Wes cese referred to medical exeminar?			28. Plece of De	eth <i>(Check only o</i>			
o	5 00	2	1 ☐ Yes 20 No		ER/Outpetient 3 1		loma 5 ☐ Resid			
o	After fund	tlon	1 Neturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow Injury occurr	ed	
VISI	Attending er death. ector: After by the fune	Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injury - At he	ome, farm, street, facto		28f. Location (S	Street and Numb	er or Rural I	Route Number,
ā	ital or rel Dir lled in		V S TOMOGO	building, efc. (Specifi	y) 		City or Tow	n, State)		
	Hosp 24 hor Fune Fune etaly fi	edicai	29e. Certifier (Check only one) 1 Certifying Physical Examination	olclan: To the best of my kno- ner: On the basis of examine	wledge, deeth occurre tion and/or Investigation	d et the time, dete end plece on, in my opinion, deeth occu	and due to the ourred et the time, o	ause(s) end ma lete end place, o	nner as statend due to the	ed. ne cause(s)
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral	X	29b. Signeture end titla of certifier	and menner steted.	2	9c. License number		29d. Data signed	d (Month, Di	ay, Year)
			· WW	1		D 48098.				
			30. Neme and eddress of person who co	mpleted ceuse of death (Item	n 23e) (Type, Print)					
	Cha		31. Dete filed (Month, Day, Year)	32. Registrar's Signe	dura -					
	Stat Registra	-	1111 8 1999	Beneva	5. Some	41				

Tribbie a section Midell It do to 1. 1. 1. The many the property of the state of the st EV - X - KING - 1:- 25 Mary Jaly Tagasino (- M THE TRUMP TENT NOT House ! See Section 1 The state of the s Anticon Elliga Depois Off Core ST Crassed, MD 50813 all the factor of Profer - process from the

marifu to manage EER & 10

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death

2. Date of Death

Month

3. Tima of Death

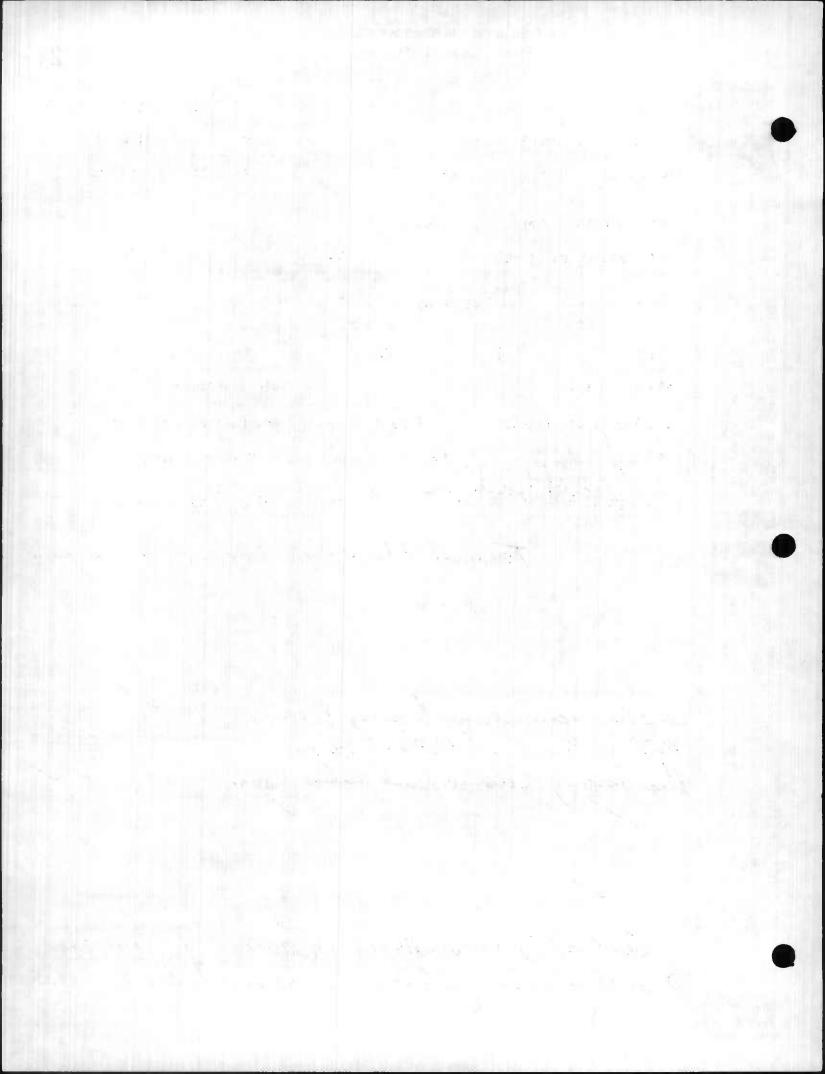
Physician /Medical Examiner
Funeral Director
and m

1. Decedent's Name (First, Middle, Last)

^{Dey}1999 Marion Cieplak, Sr. July 17, 3:05 AM 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth St. Elizabeth Nursing Home **Baltimore** Baltimore H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 9. Birthpiece (State or Foreign Country) 1913 Poland 7. Age (In yrs. last birthday) Months 1 € M 2 □ F Yrs. 086-12-0517 85 Nov. Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryli Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-f shown in Injury or other traumatic event, in Medical Examinet must be notified an once. 1 Yes 2 No Directo Maryland Prince George's Accokeek 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 20607 USA 15704 Blackburn Street Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 X Yes 2 No
If Yes, Give
Year or Detes: 1944-45 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Retail Sales Owner 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Valeria Pazerow Stanley Cieplak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Reletionship (Type, Print) Stanley MacCieplak-Son 1305 Mill Creek Road, Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from Stety
4 Donation 5 Other (Specify) St. Mary's Cemetery 7-20-99 Piscataway, Maryland 5 Other (Specify) 21. Signature uneral Service (ice 22. Name and Address of Fecility Huntt Funeral Home, Inc. M00053 Mark Brohawn G. P. O. Box 156, Waldorf, MD 20604-0156 23a. Part1. Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): for use as signed by the a 23b. Did tobacco use coglificate to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed i certificate has b 1 Yes 2₽ No weenc 25. Was cash referred to medical examiner? or Attending Physician: funeral director. Be 26. Place of Death (Check only one) Other: 4 Lursing Home 5 Residence 6 Othar (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Manner of Deeth Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Naturel 5 Pending death. 1 Tyes 2 🗆 No investigation within 24 hours after death To the Funeral Director: / completely filled in by the 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name end address of person who completed ceuse of death (ttem (23a) (Type, Print) 21228 M. MACHIRAN 720-C 31. Date filed (Month, Day, Year)

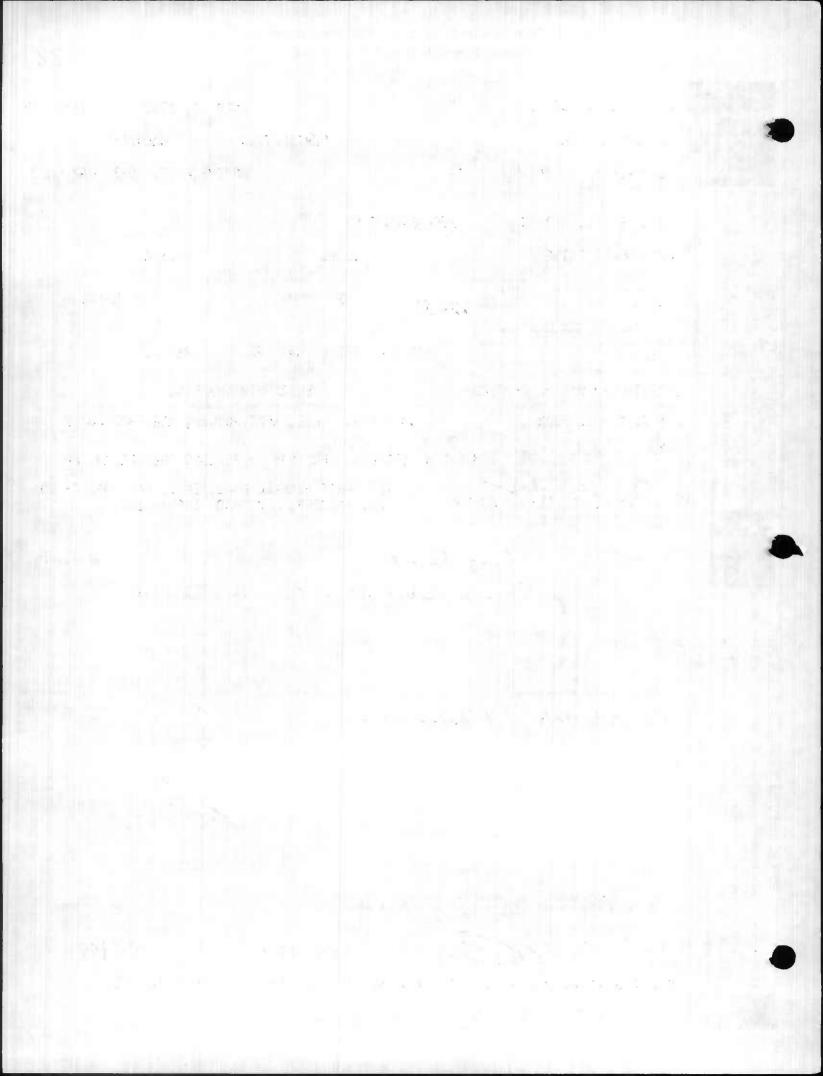
JUL 2 0 1999 32. Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene 99 23922

						Ce	rtificat	e of L	Death		R	eg. No.		0 2 6 6
	DI i - i		1. Decedant'a Nama (First, Middle, La								2. Dete of Deal		Year	3. Time of Death
	Physici - /Medi		JAMES LEWIS CAR	RRICO						J	JULY 17		1001	11:15 PM
7	Examir		4a Fecility Neme (If not Institution, gh 763 MONARCH LANE					H	JNTIN	IGTOWN		4c. County	ERT	
	Funeral Director			Sex 7. A 1 M 2 □ F	ge (In yrs. last 71	birthdey) Yrs.	Months Months	Deys	If Under Hours	Min	8. Data of Birth (Month, Day 10VEMBE)	Year) R 27, 1	9. Birthi Coul 927	pleca (Stata or Foreign ntry) MARYLAND
	ylend		10a. State 10b. County		10c. City, To	own or Lo	ocation							10d. Inside City Limits
	Ba-f s	Director	MARYLAND ST. MAR	RY'S	MECHA	ANICS	SVILL	E						1 ☐ Yes 2 No
	ith with the Marylen 23a or 28a-f show		10e. Street and Number 40343 WOLFE DRIVE				10f. Zlp				1	0g. Citizen of		ntry?
	ne 23	Funeral	11. Marital Status	12. Was Decedan	t Evar in U.S.	13.		0659 dent of Hi	spanic Or	igin? (Spec	ify Yas or No-	U.S.A.		can Indian,
21215-0020	within 72 hours efter death with the Maryland ene. then "natural", or itema 23a or 28a-f show he Medical Examine must be notified at	by	1 Navar Marriad 2 Married 3 Widowed 4 Divorced	Armed Forces 1 ☑ Yas 2 ☐ If Yes, Give Year or Datas:	No		If Yas, spe	city Cube	Specify.	n, Puerto R	lican, etc.)	Specif	ck, White, y: WH	etc. ITE
5	natural',	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		6a. Dece (Give	dent's Usu kind of wo	ork dona d	luring mos	at of workin	9	16b. Kind of B	usinass/In	dustry
121	within lene. then	Completed	Elementery/Secondery (0-12)	College (1-4or	5+)		& SE			AGER	1	RETAIL		
9	Hygi ther ther	Be Co	17. Fether's Neme (First, Middle, Last)			G 01				(First, Middle, I		na)	
/lar	Mantal Marked o	To B	CHRISTOPHER WALTO	N CARRICO					ELIZ	ABETH	THOMP:	SON		
, Maryland	d 2 sho th and T is m trsum		19a. Intermant's Name/Reletionship (_				Route Number			
Baltimore,			20e. Method of Disposition 1 Dunial 2 Cramation 3 C 4 Donation 5 Other (Speci	Removal trom State	20b. Plece cema	of Disponitery, crea	osition (Nemetory or o	other plec		Y 7/	Data 22/1999	20c. Location		
Balti	permit. Peges Department of Important: If it any injury or o	J	21. Signature of Funaral Service Lice	nsee	164	2	2. Neme e	nd Addres	s of Facili	RAL H	IOME, II	NC., PO	ST 0	FFICE BOX
	Physician		23a. Pent1. Entar the disease, or comshock, or heen tellure. List only	plications that ceuse	ed the death. D	o not en	ter the mod	WALD(de ot dying	JRF, g, such es	MARYL cerdiac or	respiratory err	0604 - 01	56	Approximete Interval Between Onset and Deeth
3	/Medical		Immediete Ceuse (Finei disaesa or condition	4	C									2 mon Tha
	Examiner		resulting In death)	0	Due to (or as	e conse	quence of)	:	_					DY MON THUS
	pet listi	Examiner		· Chron	ric C	65	ruct	اباو	Pu	lmon	Ary I	SEASO	2	
,	execu in and ial-tra	Exa	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es	e conse	quence of)				,		-	
68760,	certificate be executed rding physician and use es the burial-transit	edicai	Cause (Disease or Injury that initiated events resulting in deeth) Lest	C	Due to (or es	e consec	quence of):							
	eath certific attending pl	2		d										
Box	atter for 1	clan	Deat II Oaker also little and assertial assert		h						anh Dida			a Aba a a usa a di da abi 0
о. О.	the cy the achec	by Physician/	Pert II. Other significant conditions		_				en in Part	I.	236. Did to			o the cause of death?
Ś	es the	by P	Canotid Ani	sux #1	heros	Cle	10513	5						
of Vital Record	aw requii	Completed		,							24a. Was e perfor		an Co	fere autopsy findings vailable prior to empletion of cause death?
Ĭ	The ate h	Com									104	es X No	1	□Yes 2□No
Z	ysicien: The s certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	14.12	125	- 0	Oth	26. Piec	e ot Deeth	Check on	SON		
0	Phys this ral di	- T	1 ☐ Yes 2 ☑ No 27. Manner of Deeth	Hospital: 1 ☐ Inpat 28e. Dete of Inj	ient 2 ER/	Outpatie		-	4 🗆 14		a 52 Reside			(y)
	Attending or deeth.	ation	1 Natural 5 Pending 2 Accident Investigation	(Month, D	ay Year)	Injury	М	28c. Injury Worl 1 ☐ '	(? Yes 2□	1				
Division	or Attending Perfector: after deeth. Director: After din by the funer	Certification:	3 Sulcide 6 Could not be determined	286. Piece of it	njury - At home, etc. (Specify)	term, st	reet, tector	y, office		2	8t. Location (S City or Town		ber or Rur	al Route Number,
	d hours uners aly fille	edical C		nysician: To the best miner: On the basis and mannar s	ot exemination									
	within 2 To the F	M	29b. Signeture and title of certifier		-	2	29	c. Licanse	number		2	9d. Data signe	ed (Month	Day, Year)
			ple A	lans	1			D3	048	84		7	19	99
				completed cause of MOSELLA,			Print)				HEIGHT	rs, MD	2074	18
	Sta Registr		31. Dete tiled (Month, Day, Year) JUL 2 0		trer's Signeture	15	. M	Con	41					



State of Maryland / Department of Health and Mental Hygiene 99 23023

			Ce	rtificate of	Death	F	Reg. No.	200	20
Div.	1. Decedent's Neme (First, Middle,	Last)				2. Date of Dea Month	ith Day	Yeer 3. Time	of Deeth
Physician /Medical	Vivian		D:	iggs			19,199		0 am
Examiner	4a Fecility Name (If not Institution,	give street and number)			4b. City, Town, or				
	Southern Mar	vland Hosp	ital		Clinton	1	Princ	e George	25
Funeral		3. Sex 7. Age (n yrs. last birthday,	if Under 1 Yeer	If Under 24 Hrs.	8. Dete of Birth	h Vasal	9. Birthpiace (Stat	e or Foreign
Director	220-34-9169 Usuai Residence of Decedent	^{1□ M} 2 F 60	Yrs.	Months Days	Hours Min.	Februa	ry 23,	9. Birthpiace (State Country) Washing	ton D
8 m	10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. insida	City Limits
4 P	MarylandPrince	Georges I	Jpper Ma	arlboro				¥□Y	es 2 No
s 23e or 28e-f show vat be notified at rai Director	10e. Street and Number	0001900	oppor	10f. Zip Code			10g. Citizen of V	Vhat Country?	
		der Dood		2077	2			CA	
	13303 Van Bra	12. Wes Decedent Eve	er in U.S. 13.	Was Decedent of I	Hispanic Origin? (S	pecify Yes or No-		S,A. - American Indien	
Darwing Liver Liver By Funeral		Armed Forces? 1 Yes 2 No If Yes, Give X Year or Detes:		tt Yes, specify Cub	en, Mexican, Puer	o Rican, etc.)	Specify		
edical Exa	15. Decedent's	Education	16a Dece	dent's Usuai Occu	pation			Black usiness/Induatry	
r, tre Medical I	(Specify only highest	grade completed)	(Give	kind of work done DO NOT use retire	during most of wo	rking			
DE C	Elementery/Secondary (0-12)	College (1-4or 5+)		etitian			State	Governm	ent
evant, Be Co	17. Father'a Name (First, Middle, La	ast)	DI	CITCIAII	18. Mother's Na	me (First, Middle,			
B		Windsor	Sr.						
F	19a. intormant's Name/Relationshi			ing Address (Street	Leora	iral Route Numbe	Brano		
To									7.2
	Gwendolyn Digg 20a. Method of Disposition		20b. Place of Disp	osition (Name of		per Ma		MD 20 / City or Town, State	
×	1 ☑ Buriai 2 ☐ Cremation 3	Removal from State	cemetery, cre	matory or other pla					
2	4 Donation 5 Other (Spe					n. //22	/99 Su	itland	MD
any injury o	21. onatur of 5 peral Service Li	censee	2	2. Name and Addr	ess of Facility				
Importan any injur 2008.	1/ Hay	2 ×	Ada	ams Fund	eral Hor	ne P.A.	, Aquas	co MD 2	0608
	3a. Part1. Enjoy the dimense, or coshock, or heart failure. List of	omplications that caused to	death. Do not en	ter the mode of dy	ing, such as cardia	or respiratory er	rest,	Approximation to the control of the	nete
ician	orong of mount famoro. Elot of	ny sangangan da dada mao.							nd Death
dical	tmmediate Cause (Final disease or condition	Cardia	a.C	Arrest					
iner	resulting In death)	a	e to (or as a conse						
e e				quence ory.					
mir	Convention list and its		tension e to (or as a conse	quence ot).					
the buriat-transit	Sequentially list conditions, if any, leading to immediate			querios otj.					
		9.	Cancer	munana att:					
	resulting in death) Last		e to (or es a conse						
Physician/Me		d. Type	II Diabe	etes				1	
1012	Part ii. Other significant condition	contributing to death but r	not resulting in the o	underlying cause of	iven in Part i.	23b. Did t	obacco use co	ntributs to the caus	es of death?
/ Physic						101	Yes 2□No	3 Probably	Unknown
0									
page 2 should be Completed by						24a. Was perfo	an autopsy rmed?	24b. Were autop eveilable pri completion	or to
m 2 s							/	ot deeth?	
Cog						101	res 2 No	1 ☐ Yes 2	≥□ No
5 4					26. Place of De	ath (Check only o	ne)		
E 2		Hospital:	2 ER/Outpatie	ont 3□ DOA	ther: 4 Nursing I	lome 5 ☐ Resid	dence 6 Oth	er (Specify)	
ed in by the funaral Certification:		28a. Date of injury (Month, Day Y	(ear) 28b. Time (Wo	ry et ork?] Yes 2 □ No	28d. Describe t	now injury occur	red	
d in by the funar	2 Accident invastiga 3 Suicide 6 Could no	t be Ope Diego of injury	- At home farm et			28f. Location /5	Street and Numh	er or Rural Route N	lumber.
in b	4 Homicida determin	building, etc. (Specify)	root, idotory, office		City or Tox			
completely filled in by Medical Certif	29a. Certifier 1 Certifying	Physician: To the best of n							-(0)
pletely filled edical Co	(Check only 2 Medicat Ex	caminer: On the basis of ex and manner stated		nvestigation, in my	opinion, daeth occi	irred at the time, o	date end place,	and dua to the caus	e(S)
eld moo	29b. Signature and filte of certifier	/		29c. Licen	se number		29d. Data signe	d (Month, Day, Yea	r)
	Atotas H	1000 in		DO	050390		7/21/	99	
	30. Name and address of person w	no completed cause of doct	h (itam 23a) (Tues		050389		1/21/	77	
	55. Harristand address of person w	o completed cause of deal	,, (ιαπ 23a) (Type	,					

State Registrar

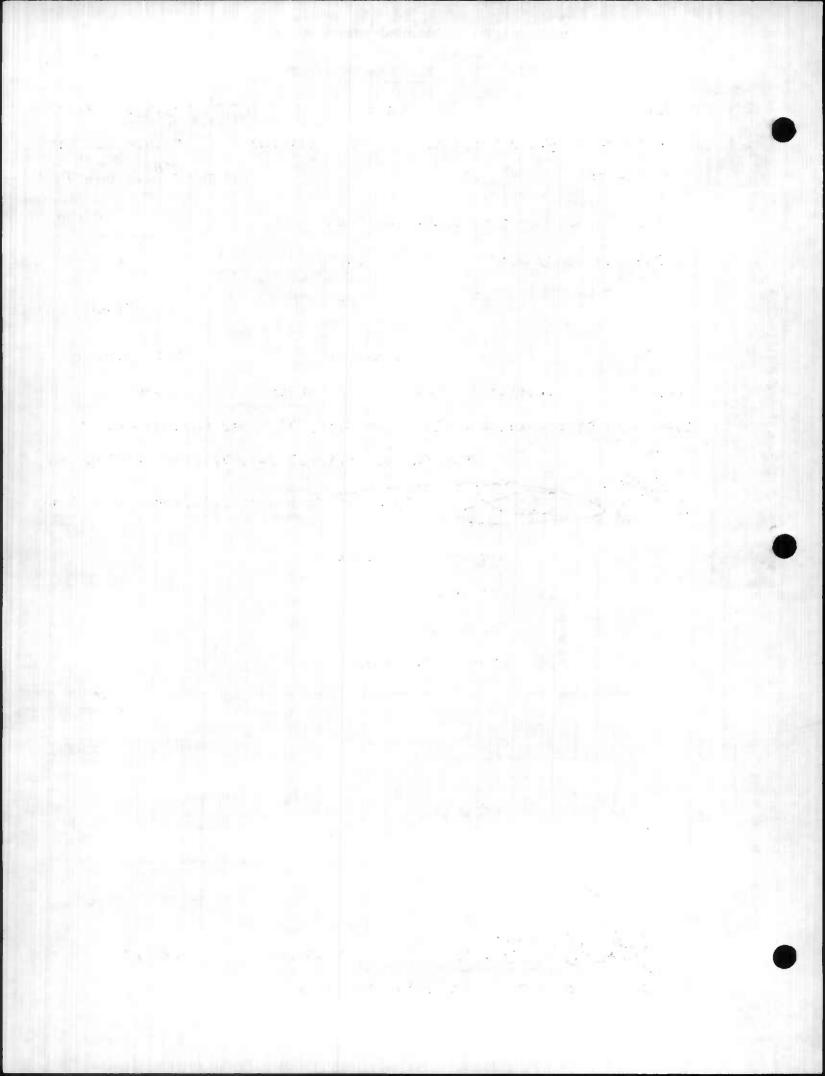
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900 E. Swan Creek RD. Fort Washington, MD 20744

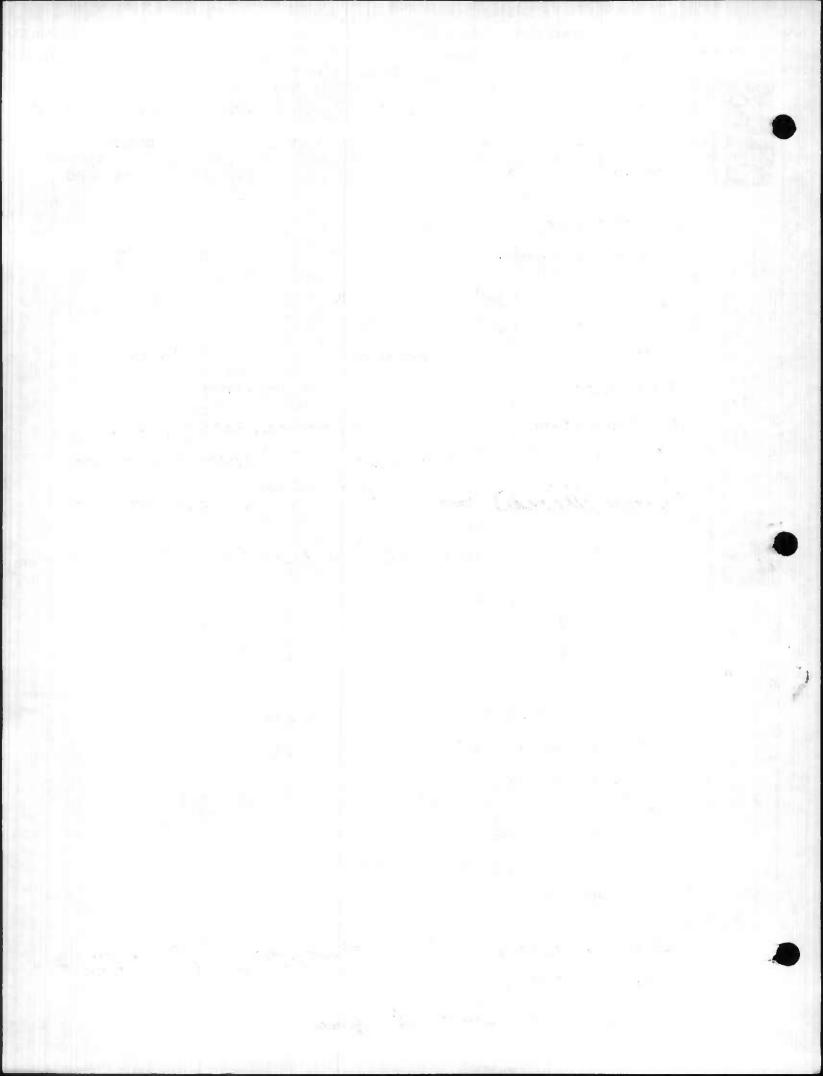
31. Date filed (Month, Day, Year)

32. Registrar's Signature



					, maryian		rtificate of		na wentai		. No.	6.	3924
	D1 2 2		1. Decedant's Nama (First, Midd	la, Last)						of Death		V	3. Time of the
	Physic /Medi		Naomi			Dona1	ds		July	່ 12,	1999	Year	6:30 AM
	Exami		4a. Facility Nama (If not institution	The second second					n, or Location of	Death	4c. County		- 0.00 0 0.00
			408 South Car 5. Social Sacurity Number			dona feliate de 1	If Undar 1 Yaar	Fruitl		4.50.0	Wicor		
d,	Funeral Director		214-30-8536 Usual Rasidence of Decedant	6. Sax 1 □ M 2 1 F	7. Aga (In yrs. 68		Months Days		Min. (Mon 12/0	of Birth th, Day, Y 4/193	(ear) 30	9. Birthpl Count Mary	aca (Stata or Foraign try) Land
	land w #		10a. Stata 10b. County	,	10c. Cit	y, Town or Lo	ocation					10	Od. Insida City Limits
	filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or Itema 23e or 28=4 show ent, The Medical Examiner must be notified a	ō	Maryland Wicom	ico		Fruit	land						1 □ Yas 2 No
	or 284	Director	10e. Street and Number			11010	10f. Zip Coda			100	. Citizen of V	/hat Coun	iry?
	23e		408 South Camde	en Avenue			21826	6				USA	
	ter death w Items 23e	Funerai	11. Marital Status	Armed Fo		S. 13.	Was Decedent of If Yas, specify Cut	Hispanic Originan, Maxican, I	n? (Specify Yas Puarto Rican, at	or No- c.)		a - Amarica k, Whita, a	
20	, or l	by F	1 ☐ Nevar Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	K Voc Ch	/a		1 □ Yas 2 🗷 No	Specify:			Specify		
0	"natural",	Pe	15. Decedar	nt's Education	atas.	16a. Deced	dant's Usual Occu	pation		16	b. Kind of Bu		hite
21215-0020	a. a. an "natu	Completed	(Specify only higha Elamantary/Secondary (0-12)	st grada complatad) Collega (1	-4or 5+)	(Giva lifa.	kind of work dona DO NOT usa retire	during most o	of working				
21	ed withir ygiena. er than t, r. k.	Con	11	_		House	wife				Own Ho		
pue	tal H off	Be	17. Fathar's Nama (First, Middla,	Last)					s Nama (First, M		idan Sumam	a)	
Maryland	2 should be filed withing and Mental Hygiena. Is marked other than aumetic event, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental co	2	Arthur Benton 19a. Informant's Name/Relations	ship (Gene Deint)		405 14-115	A 4 4 (C)		da Miste	-	n.i. w		
Ma			Art Donalds/			1	ng Addrass (Stree						
CO CO	of Haalth Item 27 I		20a. Method of Disposition	3011	20b. P	lace of Dispo	outh Cam		Data		c. Location -		
mo	Paga sent o nt: If I		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		matory or other pla metery	ice/	07/15	/99 4	Allen,	Mary	land
Baltimore,	Department of H Important: If the eny Injury or ot once.		21. Signature of Funaral Sarvice				Nama and Addr.	ass of Facility		00,	122011,	riul y	Laria
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			23a. Part1. Entar tha diseasa, or shock, or haart fallura. List	complications that c	aused the death	n. Do not ant	ar tha moda of dy	ing, such as ca	ardiac or rasptra	ory arras	t,	, , , ,	Approximata Intarvat Between
	Physician		snock, or haart tailura. List only one cause on each line.										Onset and Death
	/Medical Examiner		Immediata Causa (Finat disaasa or condition rasuiting to death)	a. Chi	'our	C 01	Ava	tev	e lun	ng	Erse	Ric	30400
		ē			Dua to (or	r as a consac	quance of):			0))
	siclan and burial-transit	Examiner	Sequentially list conditions	C b.	Dua to (o	r as a consaq	mance of).						
o,	eta be axecuted hysiclan and the burial-transit		Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury)			1-10-0-17						
	the Art	dicai	that initiated events resulting in death) Last	С	Due to (or	as a conseq						, a	
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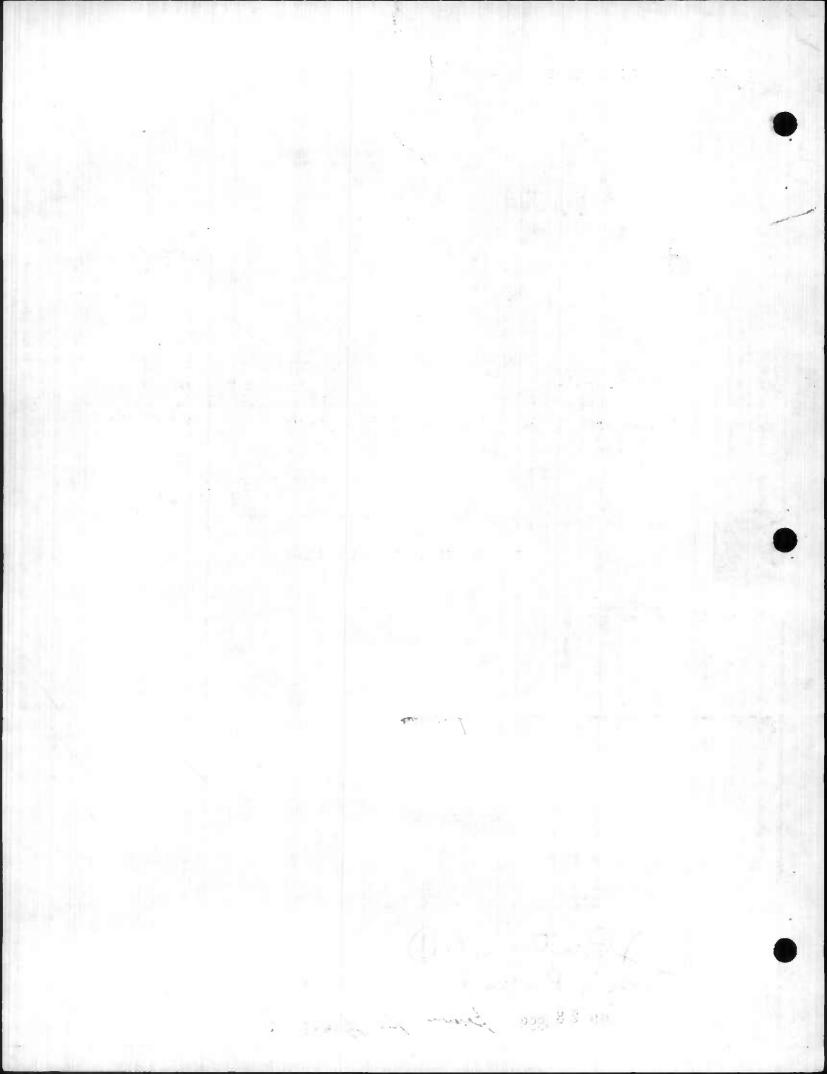
DHMH 16 Rev 6/95



State of Manyland / Department of Health and Mental Hygiene

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		80"	Buss	V	-	La	

ASP AMEND ITE	MS: #23 PART I, 27, PER MEO G773 7-30-99 WR. Certificate of De		Reg. No. 99 23925
Physicia	LICKA UGIOTO DOATS	2. Date of D Month JULY	Pey 1999 1:55 A
/Medica Examine	4a Facility Neme (If not institution, give street and number) 4b. (City, Town, or Location of Dea	th 4c. County of Deeth PRINCE GEORGES
Funeral Director	5. Social Security Number 212 66 6153 6. Sex 7. Age (In yrs. last birthday) H Under 1 Year If Months Days II	1 Under 24 Hrs. 8. Dete of B Hours Min. (Month, D Feb 1	irth 9. Birthplace (State or Foreign Country)
Maryland a-f show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Upper Marlboro		10d. fnside City Limits 1 ☐ Yes ★★ No
th with the	Upper Marlboro 10e. Street and Number 15301 Grey Fox 11. Marital Stetus 1 Never Married 1 1 Never Married 1 1 Never Married 2 Merried 1 1 1 1 Never Married 2 Merried 1 1 1 1 Never Married 2 Merried 1 1 1 1 Never Married 2 Merried 1 1 1 1 Never Married 2 Merried 1 1 1 1 Never Married 2 Merried 1 1 1 1 Never Married 2 Merried 1 1 1 1 Never Married 2 Merried 1 1 1 1 Never Married 2 Merried 1 1 1 1 Never Married 2 Merried 1 1 1 1 Never Married		10g. Citizen of What Country? United States
020	3 Widowed 4 Divorced Year or Dates:	anic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.) Specify:	o- 14. Race - American Indien, Black, White, atc. Specify: White
THE R. P. LEWIS CO., LANSING, MICH.	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done durilife. DO NOT use retired) Sheet Metal.	on ing most of working	16b. Kind of Business/Industry Local 100
Maryland 212. d 2 should be filed within th and Mental Hygiene. It marked other than traumatic event, tra Mental traumatic event, tra Mental traumatic event, tra Mental traumatic event, tra Mental traumatic event, tra Men	17. Fether's Neme (First, Middle, Last)	B. Mother's Neme (First, Middle Christine Thom	
MG2: od 2: ith ar ith ar	19a. Informant's Name/Relationship (Type, Print) Carolyn Davis (WIFE) 19b. Meiling Address (Street end 15301 Grey Fox,	Number or Rural Route Num , Upper Marlbo	ber, City or Town, State, Zip Code) ro, Maryland 20772
Baltimore, permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other once.	21. Signature of Funeral Service Licensee 22. Name and Address of	722,1999 of Facility ee Funera	20c. Location - City or Town, State Clinton, Maryland Home, Inc 6633 Old inton, Maryland 20735
6876(ficata be physicia	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart feiture. List only one cause on each line. Immediate Cause (Finet disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DIS Due to (or as a consequence of): b. Due to (or as a consequence of): a. Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or rijury that initiated events resulting in death) Last Due to (or as a consequence of): d.		friervel Between Onset and Deeth
P.O. hat the d by the detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		tobacco use contribute to the cause of death? Yas 2 No 3 Probably 4 Onknown
Record law requir has been a			24b. Were autopsy findings available prior to completion of cause of death?
hy hy	25. Was case referred to medical examiner? 1	s 2 🗆 No	sidence 8 Other (Specify) how Injury occurred
DIVISION Attentures after deat real Director:	3 Suicide 6 Could not be determined 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinic and manner steted.	ion, death occurred at the time	, date end place, and dua to the cause(s)
To To Con	29b. Signature and title of spriffer O.C.M.		JULY 18, 1999
State	31. Dete filed (Month, Day, Year) 32. Registrar's Signature		nore, Maryland 21201
Registra DHMH 16 Rav 6/95	JUL 28 1999 Dener B. Space		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Dorothy Elizabeth Ford 4b. City, Town, or Location of Death 19, 1999 3:55 PM 4a. Facility Nama (If not institution, give street and number) 4c. County of Death Hart Heritage Estate Harford Street If Undar 1 Year | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1 M 204 79 Yrs. 168-14-3952 Aug. 12, 1919 Maryland Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits Harford White Hall 1 Yas 2000 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 5348 Norrisville Road 21161 USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ 150 If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 XMdowed 4 ☐ Divorced 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elamentary/Secondary (0-12) Collega (1-4or 5+) Elementary School Teacher Education 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Emma Estelle Hess Charles Marvin Merryman 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5454 Norrisville Road, White Hall Robert M. Ford/Son 20b. Place of Disposition (Nama of camatary, crematory or othar place) Norrisyille United Methodist emetery 7/22/99 White Hall, 20a. Method of Disposition X⊠Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signulare of Funara Sarvice Ucensee, 22. Nama and Addrass of Facility J. J. Hartenstein Mortuary 19 S. Main St., Stewartstown, PA 17363 45 Low 23a. Part / Entertha disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or bean failure. List only one cause on each line. Approximata Intarval Between Onset and Death CEREBEAL UPSCULAR DISEAU immediata Cause (Final Sev. years disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disease or Injury that initieted evants resulting in death) Lest Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 000 3 Probably 4 Unknown HyperKNI.ON 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of daeth? 1 Yes ZEM TLI Yes 2 No As steD 26. Place of Death | Check only ona! Other: 4 Nursing Homa 5 Rasidance 6 Nomar (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Seath 28a. Data of friury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred

Physician /Medical Examiner certificate be executed

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

MD

Funeral

Director

rthan "natural", or Itama 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
and: If tem 27 is marked other than "natural", or items 23s or 28s-f show any or other than the Medical Exert, in the Medical Exert.

altimore, Maryland 21215-0020

Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 2

Records, P.O. Box 68760,

Division of Vital

Physician/Medical à Completed Be

Medical

29a. Cartifier

25. Was case referred to medical 1 Yes 2 No

1 Natural 2 Accident 5 Panding Invastigation 3 ☐ Suicida

6 Could not be datamined 4 ☐ Homicida

NIA

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and piece, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On tha basis of examinetion and/or invastigation, in my opinion, death occurred at the time, dete and piece, and dua to the causa(s) and manner stated.

(Check only one) 29b. Signatura and titia of certifier

29c. License number 9889 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated cause of daath (Itam 23a) (Type, Print) ALGRAD SPAMUS 615. W.MACPHAIL

31. Data filed (Month, Day, Year)

28 1000

32. Registrar's Signatura

M S T I II III ment or we see the second CHRISTOSHER M. 99-4194-033 UNK 99-155

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

a	sn
u	J.

Physician

/Medical

Examiner

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month CHRISTOPHER MARSHALL GROVES JULY 18 1999 1:20 A 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MARYLAND ROUTE # 04 & SUITLAND PKWY FORESTVILLE PRINCE GEORGES 9. Birthplece (Stete or Foreign Country)
1971 VIRGINIA 5. Sociel Security Number 7. Age (In yrs. last birthday)

Funeral

The law requires that the death certificate be executed burial-transit and physician 4 88 use i has page 2 certificate Attending Physician: luneral director, this To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At 6

Director the Maryland 10a. Stete ahow reast be notified at MARYLAND Directo Funeral flerne. 11. Merital Status filed within 72 hours after 21215-0020 6 by "natural" Completed Hygiene. Baltimore, Maryland . Pages 1 and 2 should be fill timent of Health and Mental Hant: If Hem 27 is marked oth Jury or other traumatic even Be permit. Page Department of Important: If any Injury or once. JPK **Physician** /Medical disease or condition resulting in deeth) Examiner Examiner Box 68760 Physician/Medical P.O. Division of Vital Records. by Completed Be 27. Menner of Deeth 1 Naturel 2 Accident

H Under 1 Yeer | H Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | SEPTEMBER 22, 1 € M 2 □ F 213-19-6310 27 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits CHARLES BRYANS ROAD 10e Street and Number 10f Zio Code 10g. Citizen of Whet Country? 3E HAMPTON COURT 20616 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? Bleck, White, atc. I ☐ Yes 2 1 No 1 ☐ Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specity: WHITE 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SALES CLERK RETAIL 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) LLOYD EARL GROVES, JR. KATHERINE MAE LAWHORNE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SUE A. GROVES/WIFE 3E HAMPTON COURT, BRYANS ROAD, MARYLAND 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State TRINITY MEMORIAL GARDENS 7/22/1999 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Septicer Licensee 22. Name and Address of Facility
THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX THE JOHN P. KNISLEY JM01164 156, WALDORF, MARYLAND 20604-0156

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Immedieta Cause (Final LUUMPLE THUMES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 N6 3 Probably 4 Unknown 24b. Wera autopsy tindings svallable prior to completion of cause of death? 24a. Was an autopsy performed? 12 Yas 18 Yes 2 No 2□ No 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Medical Certification: To 28a. Dete of Injury (Month, Day Year) 7 - \ 8 - 99 28b. Time of 28c. Injury at Work? 5 Pending 1:17 A M investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 4 Homicide MOD MURY 29e. Certifie 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. (Check only

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE 28d. Describe how injury occurred 1 Yes 2 No Delun of CD Q, IMPORTURA SEEP

281. Location (Street end Number or Rural Route Number, City or Town, State) ELA & 2011 COND DKMVA

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature end title of cartifier

29c. License number O.C.M.E 29d. Dete signed (Month, Day, Year) JULY 18, 1999

1 ☐ Yes 2 D No

Approximata Interval Between Onset and Deeth

and address of person who completed cause of deeth (Item 23a) (Type, Print) HDRYOMOR A. Wortoums

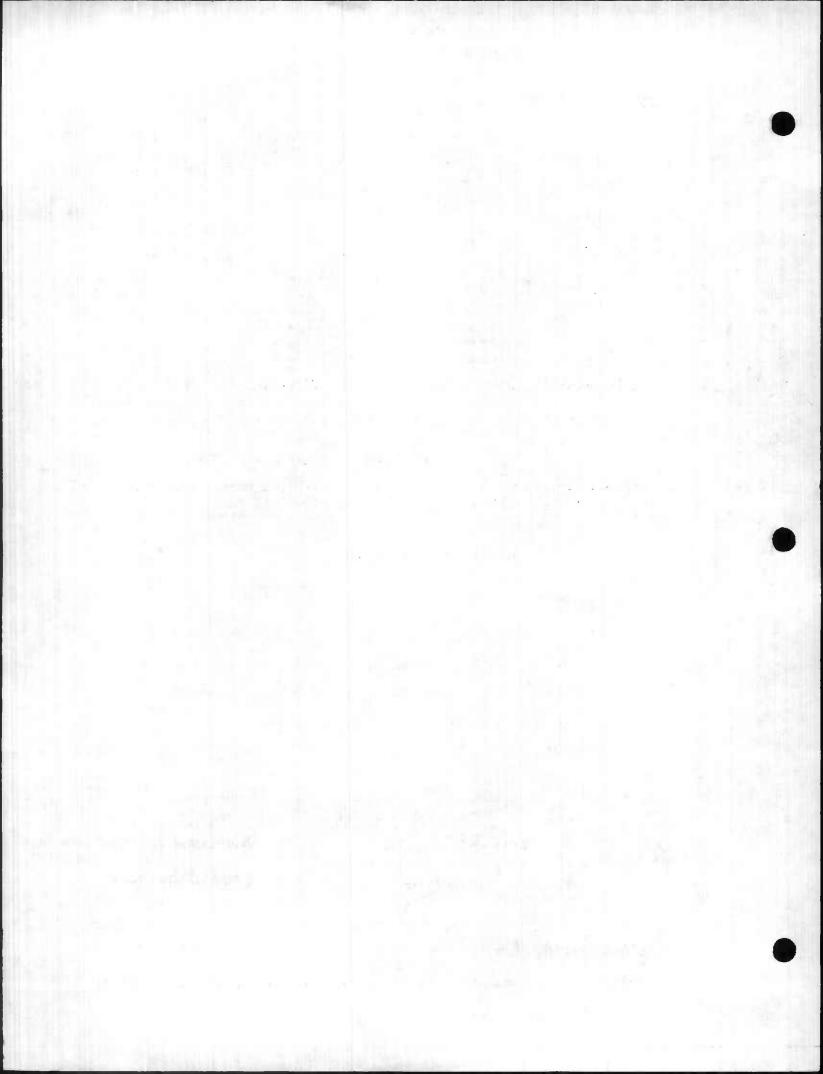
111 Penn Street, Baltimore, Maryland 21201

State Registrar

filled in

completely

31. Date filed (Month, Day, Year) JUL 21 1999 32. Registrer's Signeture Windson.



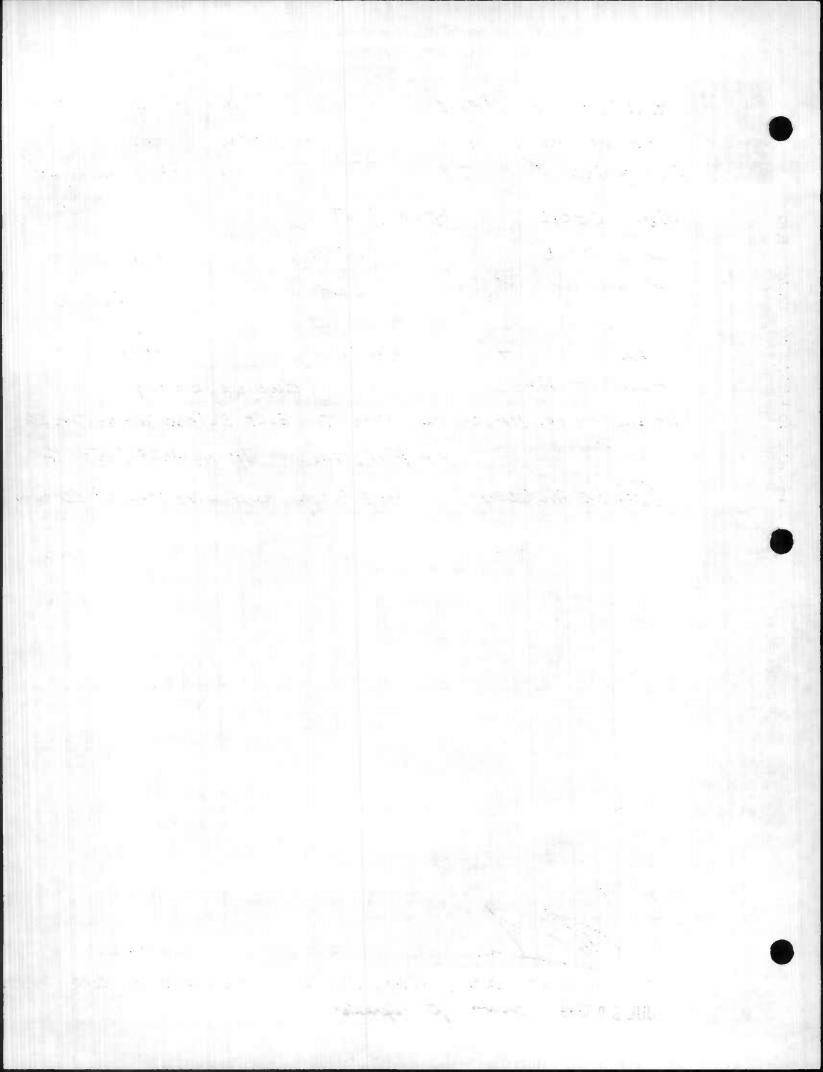
State of Maryland / Department of Health and Mental Hygiene 99 23928

Deceded From Name (First Mean) (Last) Deceded Charles Decede							Cei	rtificate	of	Death			Reg. No.		
Powerful Part of the County of Date				1. Decedant's Nama (First, Middle,	Last)									Vaca	3. Time of Death
Printed Prin	٠			Magnolia Hale								July	Dey		1930
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Physician // Redical Examiner Physician // Redical Examiner	Sall	ppan pour ny in		21. Signeture of Funaral Sarvice Li	censee		22 H i	2. Nama and	Addre	for F	y Funer	als.	P.A.		
Physician /// Case and properties of the disease, or complications that caused the death. Do not aniar the mode of dying, such as cardiac or respiratory arrest, including in death of the disease or condition assisting in death) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions can death to the cause of death (Pack only one) 25. Was case referred to medical exa	ш	89599	1	Monued	S. Hu	Das								Maryla	and 21921
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25. Was case referred to medical examiner? Second Paper		he he	E									-	Yes all No	1	Yes 2 No
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State Registrar JUL 14 1999 32. Registrer's Signature G. Sparks					Server 32. Reg	pistrer's Signatu	do.	als							

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 99 Mahe Tu 2018 /Medical 4a Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Himore 13a Mar niversitu and Medical system Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 K) F 219-30-0910 63 Jan. 8, Director Kentucky Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. foside City Limits 28a-f ahon "natural", or itema 23a or 28a-f ahov edical Examiner must be notified at 1 Yas 2KNo Cecil Director Maryland Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 Brown Road 21903 U.S.A. Funeral deeth Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Marital Status 12. Wes Decedent Ever in U.S. Bleck, White, etc. Peges 1 and 2 should be filled within 72 hours after onent of Heelth and Mental Hygiene.
Int: If Item 27 Is marked other then "natural", or he 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: White Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Duck's Place Elementary/Secondery (0-12) College (1-4or 5+) Havre de Grace, Maryland Waitress Nine Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mark Dempsey Brown Helen White 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandy L. Campbell (Daughter) 7 Meadow Walk, Port Deposit, Maryland 21904 Hern 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Peges Department of Important: If It any Injury or o 1 Burial 2 Cremation 3 Removal from State Angel Hill Cemetery 7/17/99 Havre de Grace, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Neme end Address of Facility Lee A. Patterson & Son Funeral Home wasters. Perryville, Maryland 21903-0188 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** 3 months /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the deeth certificate be executed sician and buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are this in death). Due to (or as a consequence of): Box 68760, physician the burie Physician/Medical Due to (or es e consequence of) resulting in death) Last 189 signed by the a P.O. 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 25 No 3 Probably 4 Unknown Records. þ 24b. Wera autopsy tindings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed has 2000 1 ☐ Yes 2 No of Vital Physician: 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient edicai Certification: To 2 ER/Outpetient 3 DOA this 28e. Date of fnjury (Month, Dey Year) To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Netural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, ferm, street, fectory, office bullding, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature and title of captifier 29c. License number 29d. Dete signed (Month, Day, Year) no completed cadse of death (Item 23a) (Type, Print) eene Street Baltimore Maryland Wendy L. Wright MD 32. Registrer's Signeture State Registrar

Decedent's Name (First, Middle, Last)	Cen				Reg. No.				
				2. Date of Dea		3. 1 Year	Time of De		
ALBERT G. HAL	6			July	18, 19	99" 0	6:00A		
4a Fscility Name (If not institution, give street and number)		4	b. City, Town, or L		4c. County	of Death			
	Om		Porrez D	oint	Ceci				
VA Maryland Health Care Syst. 5. Sociel Security Number 6. Sex 7. Age (Ir	n yrs. last birthday)	If Under 1 Year	Perry Po	8. Date of Birt (Month, Day			State or F		
217-14-2550 10M 20F 7	7 Yrs.	Months Days	Hours Min.	(Month, Day	13,1922	9. Birthplace (Country)	10 11 1		
Usual Residence of Decedent				MAICH	171722	mich	IGMA		
	Oc. City, Town or Loc	cation ,				10d. In	side City I		
MD. CECIL PERRYPOINT							Yes 2		
10e. Street and Number 10f. Zip Code					10g. Citizen of V	What Country?			
/ 1				U.S.A.					
				pecify Ves or No.		e - American Inc	lian		
Armed Forces?	1. Meritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto					k, White, etc.	arar 1		
3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	☐ Yes 2☐ No	Specify:	Specify: R			V		
	16a Doord	ent's Usual Occup	ation		16b. Kind of Bu	BLAC	^		
15. Decedent's Education (Specify only highest grade completed)	(Give k	kind of work done	during most of wor	king	TOD. KING OF BE				
Elementary/Secondary (0-12) College (1-4or 5+)	1	inter	,		Prod	ting			
17. Fether's Neme (First, Middle, Last)	17	INIEK	18. Mother's Nan	e (First Middle		-			
ALBERT HALL			EUN	ice B	ERRY				
19a. Informent's Name/Reletionship (Type, Print)		g Address (Street		_					
DR. WILLIAM M. HALL-B	rother 1	800 To	m BOL7						
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Remove if rom Stete	20b. Place of Dispos cemetery, crem	sition (Name of natory or other plac	e)	Date		City or Town, S	-		
4 Donation 5 Other (Specify)		MIS IN		7/19/99	West	chester	PA		
21. Signature of Funeral Service Licensee		. Name and Addre		1 1.1					
El. and Kare			/ 11	-			-11-		
Colada Micheller	E. MAIN ST. E.								
23a. Part1. Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line.	deeth. Do not ente	ar the mode of dyli	g, such as cardiac	or respiratory ar	1631,	Inter	oximate val Between on De		
Immediate Course (First						1			
Immediate Cause (Final disease or condition resulting in death) Lung cancer a Lung ca	er					unk	nown		
	e to (or es a consequ	uence of):							
						1			
Sequentially list conditions, if any, leeding to immediate	e to (or es e consequ	uence of):							
ri any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury						1			
that initiated avents	e to (or as a consequ	uence of):							
The state of the s						1			
d						1			
	et reculting la the co				tobacco usa co	ntributa to the	causs of		
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Part II. Other significant conditions contributing to death but no	ot resulting in the un	nderlying cause giv	en in Part I.				4 🗆 U		
Part II. Other significant conditions contributing to death but no	ot resulting in the un	nderlying cause giv	en in Part I.				4□U		
Part II. Other significant conditions contributing to death but no	or resulting in the un	nderlying cause giv	en in Part i.	1X1	Yss 2□ No an autopsy	3 Probably	ıtopsy fin		
Part II. Other significant conditions contributing to death but n	ot resulting in the un	nderlying cause giv	en in Part I.	1X1	Yss 2□ No	3 Probably 24b. Were at available complet	utopsy fin prior to ion of car		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death July **Physician** Spurgeon Holbrook 19 1999 Lee 11:10a.m /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Yaar | If Undar 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 180M 2□ F Yrs. 212-12-0867 82 Director June 10, 1917 Maryland Usual Rasidence of Decedant with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or itama 23s or 28s-f show other traumatic evant, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Cecil Colora 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 32 Boxwood Lane 21917 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiena. Important: If ham 27 is marked other than "natural", or flas any injury or other traumatic avant 1 ☐ Yas 2 🔯 No If Yes, Giva Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Davidson Transfer & College (1-4or 5+) Truck Driver Storage Company 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Avery Holbrook Annie Edwards ည 19a. Intormant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtle Holbrook/Wife 32 Boxwood Lane Colora, MD 21917 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 X Burlal 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Conowingo Baptist Cemetery 7-22-99 Conowingo, Maryland R. T. Foard Funeral Home, P. A. 21. Signature of Furneral Service Licenses 111 S. Queen St., Rising Sun, MD 21911 Part Enter the disease, or complications that caused the de th. shock or heart tailure. List only one cause on each line. Do not enter the mode of dying, auch es cardiac or respiratory arrest, Approximeta Interval Between Onset and Death **Physician** Immedia Cause (Final disease r condition rasulting in death) /Medical Examiner certificata be axecuted burial-transit and Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to for physician a Box 68760. Physician/Medical 88 US0 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records. P 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen Pags Pags 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate director, 25. Was case reterred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how Injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28b. Tima of Natural 5 Pending 1 Yes 2 No investig 2 Accident Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19 10 who combleted cause of death (Item 23a) (Typp, Print) Whon 31. Data tiled (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Ray 6/95

Registrar

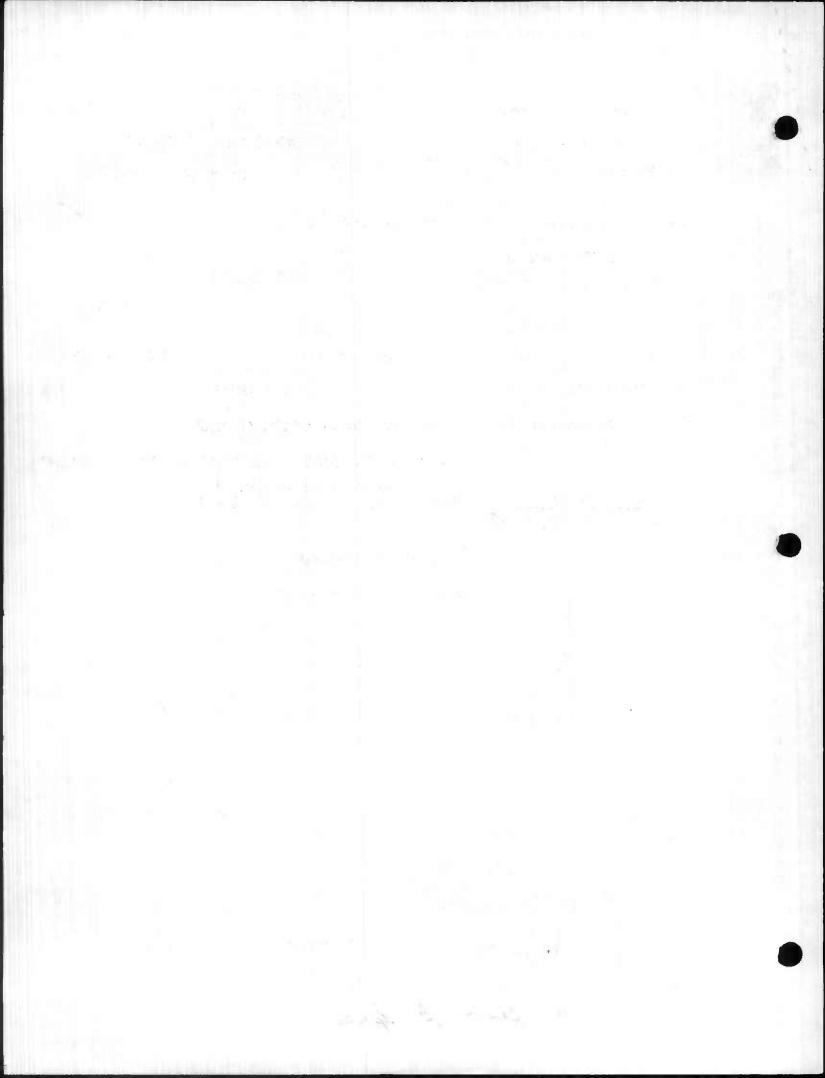
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State of Maryland / Department of Health and Mental Hygiene

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						Cen	tificate of	Death			Reg. No.		40006	
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	Physici /Medi		ELIZABETH	HALL						Month 07	02	Yaar 99	7:35 A.M.	
	Examir		4a. Facility Nama (If not institut	ion, give street and numbe	r)			4b. City, To	wn, or Lo	cation of Deeth	4c. Count			
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	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28a-f show ord, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Wes Decedar Armed Forcas	dant Ever in U,S. 13. Was Decedent of Hispanic C tf Yas, specify Cuban, Maxic			lispanic Ori an, Maxicar	panic Origin? (Specify Yas or No- , Maxican, Puerto Rican, atc.)			14. Raca - Amarican Indien, Black, Whita, atc.		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Month Vasi **Physician** EILEEN KELLY **JOSEPHS** July 1999 16 3:15pm /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not Institution, give street and number) Examiner LaPlata If Under 24 Hrs. Civista Medical Center Charles 8. Dete of Birth (Month, Day, Year) Oct. 28, 1941 9. Birthplace (State or Foreign Country) New York 5. Social Security Number if Under 1 Yeer 7. Age (In vrs. last birthdev) **Funeral** Min 1 M 2 KF Months Deys Hours 071-34-7874 Yrs. 57 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or frems 23e or 28e-f show 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show solical Examiner must be notified at 1 Yes 2 No Director Waldorf Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1102 University Place 20602-3464 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No It Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Black, White, etc. 1 Never Married 2XXX Narried White 1 ☐ Yes 2 X No Specify: Specify þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic avent, the Madical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be and Mental Edward John Kelly Veronica Agnes McGuiness 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Josephs - Husband of Health Hem 27 1102 University Place, Waldorf, MD 20602-3464 Donald E 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, Stete Department of Important: If it any injury or o 1 Buriel Cremetion 3 Removal trom State 7-17-99 Waldorf, MD Huntt Crematory 4 Doneti 5 Other (Specify) of Fune ni Syrvice) 21. Signatur 22. Name and Address of Fecility icanse Huntt Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, it heart tellure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner vascular disease Examiner physician and the bunal-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Physician/Medical es e consequence of) 88 attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yee 2 No 3 Probably 4 dunknown þ 24b. Were autopsy tindings available prior to completion of cause of death? should should Completed 24a. Wes an eutopsy page 2 1 □ Yes 2 □ No 1 T Yes 2 1750 certificate el or Attending Physicien: T s after death. Il Director: After this certificat od in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours aft the Funeral Di npletely filled in 29a. Certifier 📶 Certifying Physician: To the best of my knowledge, death occurred et the time, date and pleca, and due to the cause(s) and manner as stated. Medical 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) within 2 To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D - 2257430. Name and address of pe completed cause ot deeth (ttem 23a) (Type, Print) Robert T. Pace, MD 12070 Old Line Center, Suite 202, Waldorf, Maryland, 20602
31. Deterfiled (Month, Day, Yeer)

JUL 2 0 1999

32. Register's Signeture

B. Lone L. State

DHMH 16 Rev 6/95

Registrar

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Maryland

Pages 1 and 2 should be

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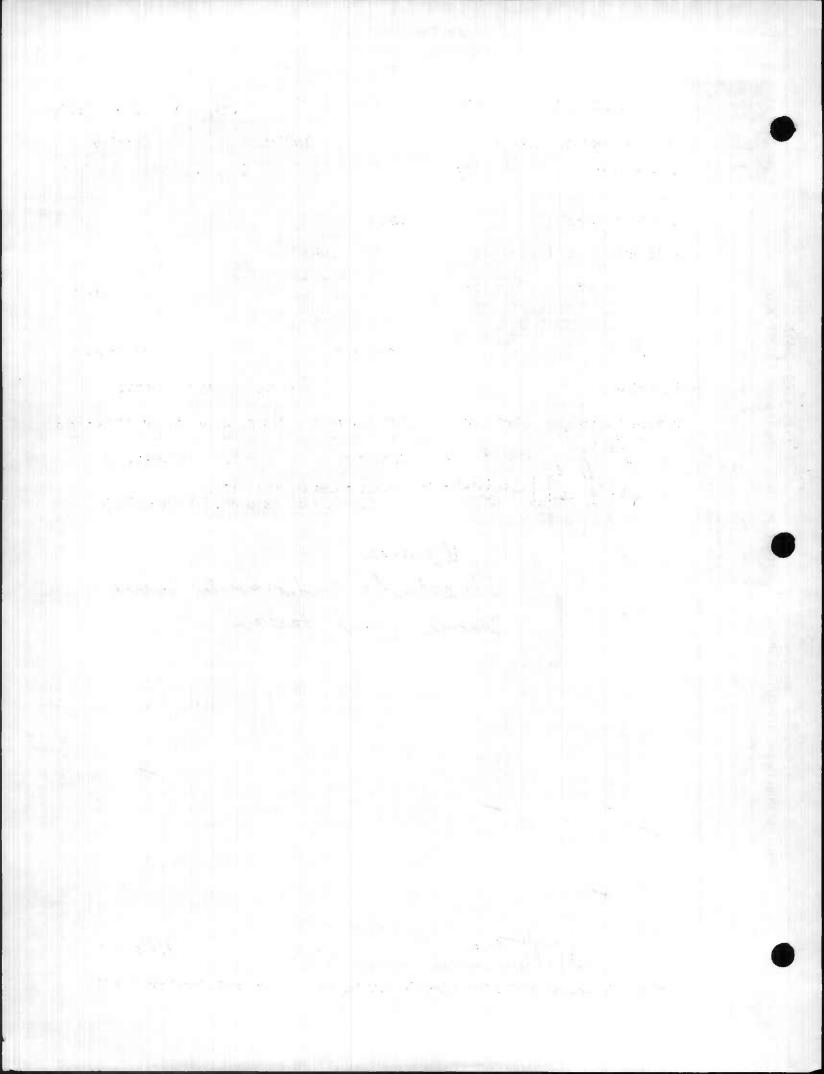
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P.O. Box 68760

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Division of Vital



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Deeth 3 Time of Death Month **Physician** HULBERT 1999 141 CARLTE **JONES** /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex, 1Д M 2□ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Yrs. MARYLAND Director 212-07-1917 10/15/1905 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Directo MARYLAND SOMERSET PRINCESS ANNE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 30380 MAPLE STREET APT. # 203 21853 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 AYes 2 No If Yes, Give Yeer or Detes:WWII 1 Never Married 2 ☐ Married Specify þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SALES 11 SALESMAN 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumame) and Mentel is marked CARLIE WILLIAM JONES SALLIE E. MASON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) of Health and Item 27 is 11984 DREXWOOD DRIVE, PRINCESS ANNE, MD. 21853 CARL PARKINSON/NEPHEW 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Peges 1 permit. Peges
Depertment of
Important: If it
any injury or o Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) ASBURY U.M. CEMETERY 7/16/99 MT. VERNON, MARYLAND 21 ig ature of Funeral Service Lisensee 22. Name and Address of Facility
HINMAN FUNERAL HOME M00295 116/3 SUMERSET AVE. FRINCES. Factors are shock, or heart tailure. List only one cause on each line. 11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853 Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 2 HK SYNDRONE SICK SINUS Examiner Physician/Medical Examiner ATHEROSCLEROTIC LARDIOVASCULAR DISERSE) 54 % certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) ATRIAL FIBRILLATION. Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? eut Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. yd bengis 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen certificate has 2 No Physician: 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No al or Attending Physics after death. 10 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA funeral 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Menner of Deet 28b. Time of 28c. Injury at Work? 1. Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the best of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier within 24 hox To the Fune completely fi edicai (Check only 29b. Signature and litle of cartifier 29c, License number 29d. Dete signed (Month, Dey, Year) wha refus 7/13/99 D051389 DR.USHA NATESAN.M.D

State Registra

DR USHA NATESAN 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

201 HALL

MGHWAY

CRISHELD, MD 21817

ERG: 1 F HIL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

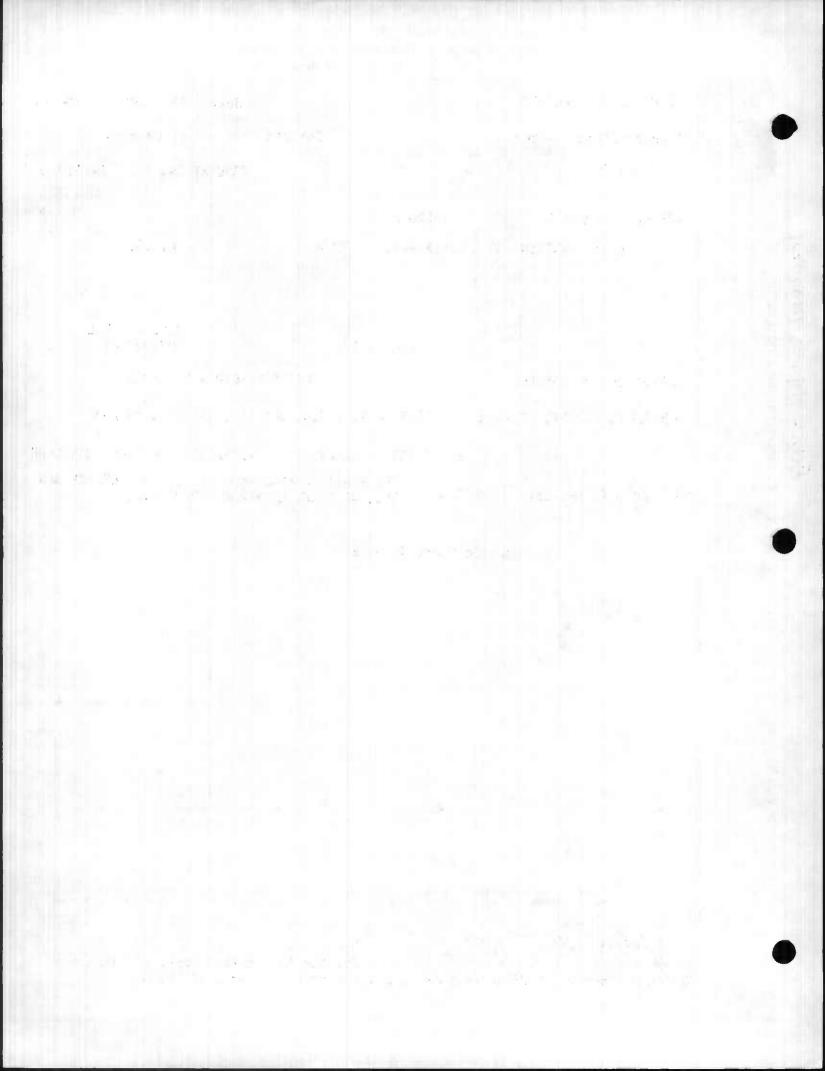
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 17 Day **Physician** FDNA AGNES MOONEY 1999 2:50 pm Ju1y /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner LaPlata Charles Civista Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (in vrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1 M 2 KF Months Days Hours 80 Yrs. 218-16-3166 MARYLAND Director JANUARY 19, 1919 Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. inside City Limite of 2 should be filed within 72 hours after death with the Manylan than death Hyglene.
7 is marked other than "naturel", or itema 23a or 28a-f show treumstic event, the Monical Examiner must be notified as 1 Yes 2 No Directo WALDORF MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Edna Hanas Mooney 20604 U.S.A. WILLETT CROSSING RD & CRAIN HWY. Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yee or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Status 1 Tes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent'a Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry U.S. FEDERAL Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT FILE CLERK 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 and 2 should be nent of Health and Mental MAMIE VIRGINIA RAWLINGS SAMUEL JOSEPH BOSWELL 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trei pncs. CRAIN HWY. - P.O. BOX 183, WALDORF, MD 20604 EDWARD F. MOONEY, SR./SON 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlat 2 Cremetion 3 Removel from State 7/21/1999 CLINTON, MARYLAND RESURRECTION CEMETERY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Vicensee 22. Neme and Address of Facility
THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX JOHN P. KNISLEY M01164 156, WALDORF, MARYLAND 20604-0156 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onset and Deeth **Physician** /Medical Immediata Cause (Final a Ischemic Heart Disease 2 hrs disease or condition resulting in death) Examiner Dua to (or as e consequence of): Examiner physician and the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or es a consequence ot): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of) 88 950 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No by The law requires 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? s certificate has b 1 Yes 2 No 1 Yes 2 No or Attending Physicien: funeral director Be 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: After 5 Pending Investigation 1 Naturel n 24 hours after death.

Ne Funerel Director: Al pletely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Sulcide 28e. Placa of Injury - Al home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. To the Fune completely f (Check only one) 250 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number Mahrice 7 a4001, 7-17-99 D - 50883 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) St. Mary's Hospital Dept. of Pathology Yakia M, Tagouri, MD 25500 Pt.Lookout Rd., Leonardtown, Maryland 20650 31. Data filad (Month, Day, Yeer) 32. Registrar'a Signature State

Registrar

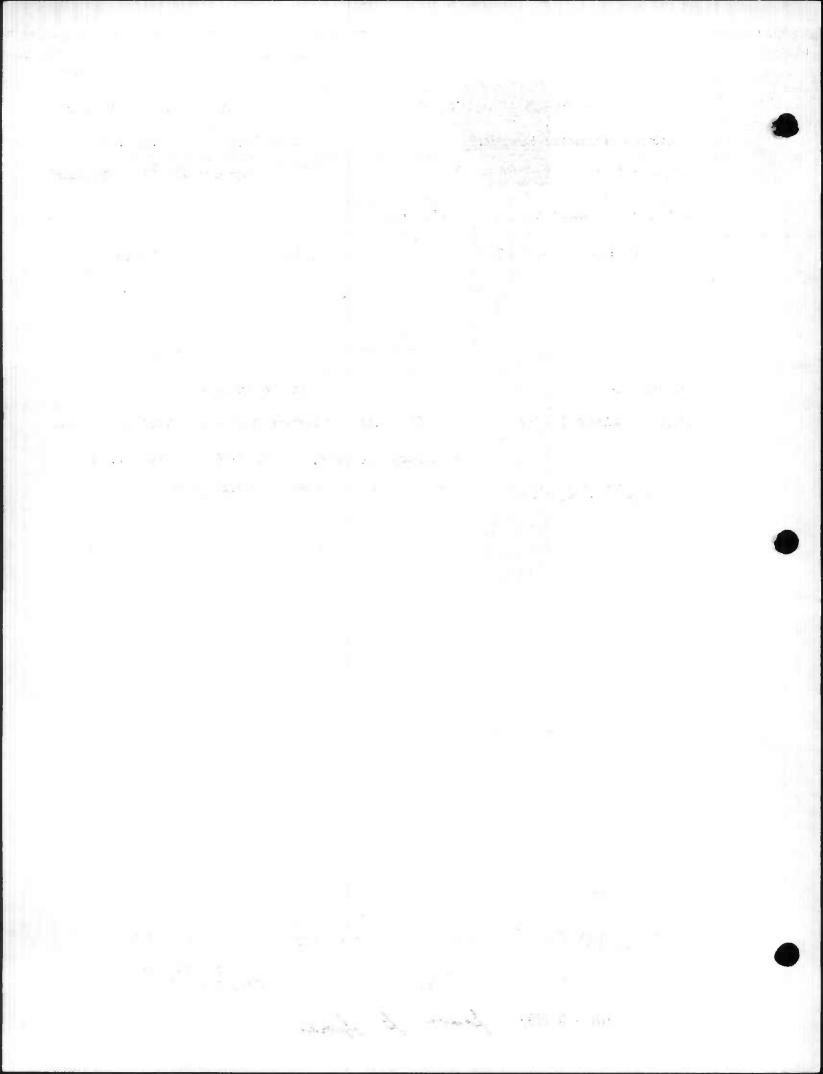
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	Funeral Director		5. Social Security Number 6. Security Number 117–14–8938 Usual Residence of Decedant	7. Age (fin MM 2□ F 76	yrs. last birthdo	Month	ler 1 Yea s Days			Birth Day, Year) Der 25,	9. Birthp Coun 1922 Mi	olace (Stata or Foreign aryland		
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	or 28	irec	10e. Street and Number	,		10f.	Zip Coda			10g. Citize	on of What Coun	itry?		
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020	al', or its	by Funeral Director	11. Marital Status 1 Never Married 2 Marriad 3 Widowed 4 Divorced	12. Was Decedant Evar Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas:	in U,S. 1		edant of pecify Cui	Hispanic Origin? ban, Mexican, Pu Specify:	(Specify Yes or erto Rican, atc.)		Black, Whita,	atc.		
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altimore,	Pages 1 annent of He Int: If Itam		20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3 ☐	Data 20c. Location - City or Town, Stata										
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Bal	permit. Pages 1 and Department of Health Important: If Itam 27 any injury or other to once.		21. Signature of Funeral Service Licens Mary Beth Brace	Trad la	us	Brad	shaw	ress of Facility & Sons ain St			D 2181	7		
	Physician /Medical Examiner		23a. Part1. Entar tha disaasa, or comp shock, or haart fallura. List only o Immediata Causa (Final disease or condition rasulting in daath)	Conge	STIV	E r	EP					Approximata intarval Between Onset and Death		
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			30. Nama and addrass of person who co BALAG URUMU	omplated causa of death	(Itam 23a) (Tyr	oe, Print))(L	MAN	201 Hal	1 High	nway			
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State of Maryland / Department of Health and Mental Hygiene 99

Physician	
/Medical	
Examiner	

Funeral

Director

the Maryland i is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

death Funeral 72 hours after à Completed filed within 7 Hygiena. 2 should be fi permit. Peges 1 and 2 sh Department of Heelth and Important: If Item 27 is m any injury or other traum **Physician** /Medicai Examiner Examiner and physician s the burial 68760 deeth certificata be Physician/Medicai Box ed by the dateched signed by t that Records, Ď Completed peed The law this certificata Division of Vital Physicien: funaral director, Be Certification: To Aftar Attending death. or Attend after death Director: / 24 hours after
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HAYNES

LARRY

NAME:

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month JULY 18, 1999 Year 9:10AM LARRY H. ORFIELD SR 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death LEONARDTOWN ST MARY"S ST MARY"S HOSPITAL If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Day, AUG 24 9. Birthplace (State or Foreign Country)
WASHINGTON, DC 5. Social Sacurity Number 7. Age (In vrs. last birthday) 1946 Months Days Hours Min 1 M 2 □ F 52 Yrs. 578-60-5238 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Maryland St Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30060 Gershwin Road 20659 IISA 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yas 2 No If Yas, Giva Year or Dates: 1 Nevar Married 2 Married Specify: White 1 Yes 2 XNo Specify: 3 ☐ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grada completed) 16a, Decedent's Usuei Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Electrician Construction 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Henry C. Orfield Virgie Freeman Orfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jerry R. Orfield (Brother) 13102 Meadow Dr Waldorf, MD 20601 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cramation 3 □ Removal from State Trinity Memorial Gardens 7-20-99 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furerai Service Licensee 22. Nama and Address of Facility
J.H. Eberwein Mortuary M00173 4433 White Pls La White Pls., MD 20695 23a. Par / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, show, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Finel 10 DAYS disaase or condition resulting in death) Imon any Sequentially list conditions, if any, leading to immediate ceusa. Enter Undarlying Cause (Disease or injury Polmonory bstructive Monic thet initiated events rasulting in death) Last Part It. Other significant conditions contributing to death but not resulting in the underlying ceusa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown END STAGE RONAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy INSULIN DEPENDENT DIABETES MELLITUS CARDLO MYO PATHY
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ HomicIde 29a. Certifier (a) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and manner as steted. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifian 29c. Licensa number 29d. Date signed (Month, Day, Year) 07/18/99

State Registrar

31. Date filed (Month, Day, Year) 2 0 1999

rank



30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

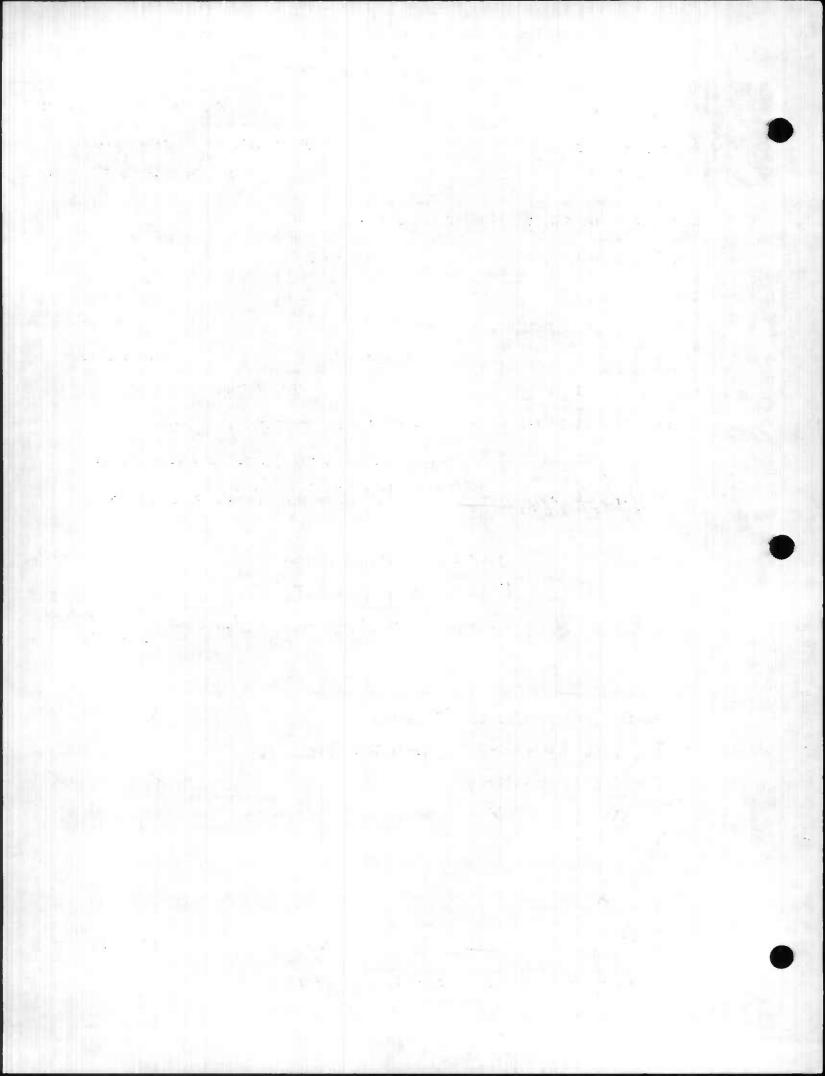
DR. FRANK L. KRIGER

MD

WALDORF, MD.

D50350

20602

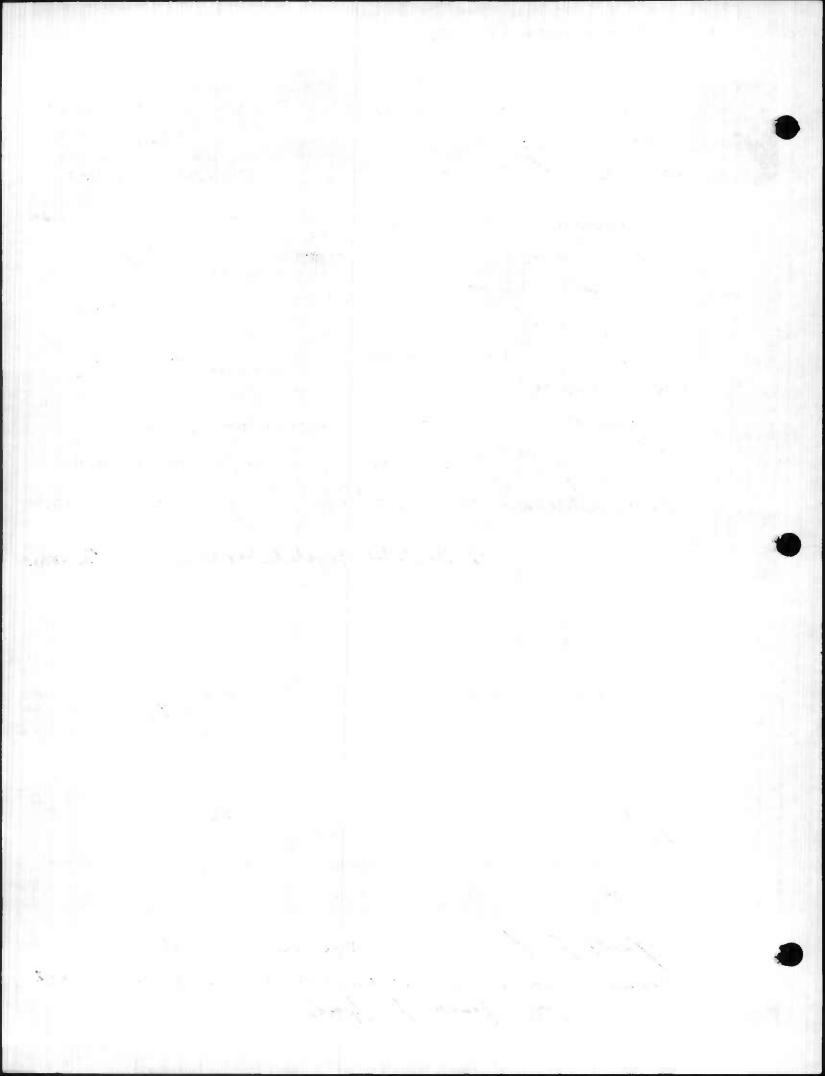


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State of Maryland / Department of Health and Mental Hygiene

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				-	-	-	-

					Cei	rtifica	te of	Death		R	eg. No.			
Div	la.	1. Decedent's Name (First, Middle, L.	ast)							2. Date of Dear	th	Vac-	3. Tin	na of Death
Physici /Medi		Lloyd	David	Ove	erho	1t				Month July	1. 19	Year 399	11	: OOAM
Examir		4a. Fecility Name (If not institution, gi			71 110	10		4b. City, To	wn, or Lo	ocation of Death	7	nty of Death	44	00/111
EAUIIII		7208 Mennonite	Church F	nad				West	OVER			erset		
Funeral		5. Sociel Security Number 6.	Sex / 7.4	age (In yrs. last	birthday)	If Unde	r 1 Yeer	If Under					niece (St	ete or Foreig
Director		218-48-5307 Usual Residence of Decedent	12 M 2□ F	53	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day) 03/26/19	946	Mary	ntry)	
within 72 hours efter death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examinat natit be politied at	o	10a. State 10b. County		10c. City, To								1		le City Limit
28s	Director	Maryland Somerset	5	West	cover		Code				1115-1-0-			
ours effer death with the Maryler felt, or items 23s or 28s-f show Examiner must be notified at	rai Dir	7208 Mennonite Ch	nurch Road	ı		101. 21	Code 21	871		'	0g. Citizen o	USA	ntry?	
r de	Funerai	11. Meritel Stelus	12. Wes Deceder Armed Forces	t Ever in U,S.	13.	Was Dece	dent of H	ilspanic Ori an. Mexicar	igin? (Sp	ecity Yes or No- Ricen, etc.)		ece - Americ lack, White,		n,
72 hours efte "natural", or it	by	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 Tes 24 If Yes, Give Year or Dates	No			-	Specify:		,		Specify: White		
within 72 ho liene. Than "natur The Medical.	Completed	15. Decedent's E	ducation	10	6a. Deced	dent's Usu	al Occup	ation			16b. Kind of			
n n n	pie	(Specify only highest gr Elementary/Secondary (0-12)		· F · \	(Give	kind of wo DO NOT L	ork done ise retired	during mos d)	t of work	ing				
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d 2 should be the end Mente 7 is merked traumetic ex	F	19a. Informant's Name/Relationship		1	Ob Mallin	n Addres	c /Stroot			al Route Number	Chu or Tou	n State 7in	Codel	
U 0 0 0		Natalie Overholt				_								
is 1 end 2 if Health item 27 i		20a. Method of Disposition	MILE	20b. Place				e Chu	rch	Road, We				
		1 Burial 2 □ Cremation 3 [☐Removel from Stet	0.000.0	tery, crer	natory or	other plea	ce)	1	Dete	20c. Location	n - City or To	own, Stai	(6)
permit. Page: Department of Important: If I any injury or		4 ☐ Donation 5 ☐ Other (Speci			on Ce	mete	ry		7	/4/99 F	ocomo	ke. Ma	ryla	and
Departing Imports any inju		21. agrature of Funeral Service Lice	nsee	.,,	nd Addre	ss of Fecilit	ty							
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		shock, or heart failure. List only	one ceuse on each	lications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory arrest, ne cause on each line. Approximate Interval Betwee Onset and De										
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/Medical		Immediete Cause (Final disease or condition	metostatic Prostate Concer 2 year											VERE
Examiner		resulting In death)	а	Due to (or es				0						7-4
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exec in an	E X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		000 0 40 00								Ī		
Sicla Dur		Cause (Disease or injury that initiated events	C											
phy:	Medical	resulting in death) Last		Due to (or as	a conseq	uence of):								
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0 0 0	Physician	Part II. Other significant conditions	contributing to death	but not resulting	g in the ur	nderlying	cause giv	en in Part I		23b. Did to	bacco use o	contributa to	the car	se of deati
by th	γh									1□ Y	08 2 XNO	3 Pro	bably	4 Unknow
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sign of blu										24a. Was a	n autopsv	24b. W	ere auto	psy findings
v requires been sign should be	Completed									perform		av.	eileble p	rior to
8 S S	npi												death?	
pag	Ö									1 🗆 Ye	95 2 No	1 (Yes	2 No
certificate rector, pag	Be (25. Was case referred to medical						26. Place	of Deat	h (Check only on	ю)			
	ToE	examiner?	Hospital: 1 Inpat	tient 2 ER/	Outpatien	t 3 D	OA Oth	AGE:	rsing Ho			ther (Specif	(v)	
Phys ar this eral d		27. Menner of Death	28e. Dete of In	jury 28t	o. Time of		28c. Injur Wor			28d. Describe ho			,,	
ding th. After fune	ţi	1 Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	м		rk? Yes 2□.						
To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	njury - At home, etc. <i>(Specify)</i>	farm, str					28f. Location (St City or Town	reet and Nur n, State)	mber or Rura	al Route	Number,
Hospital 24 hours a Funeral C staty filled		29a. Certifier Certifying Pl	husisian. To the bea					4.4						
To the Mospital within 24 hours a To the Funeral I completaly filled	edicai	(Check only one)	hysician: To the bes miner: On the basis end manner s	or examination	ige, death and/or inv	estigetion	at the tin	ne, date an pinion, dee	th occurr	and due to the creed et the time, d	ause(s) and o ate and place	manner as s e, and due to	tated. the cau	rse(s)
o the	Me	29b. Signeture end title of certifier	. /			29	c. Licens	e number		2	9d. Date sign	ned (Month,	Day, Ye	ar)
- 5 - 0		1 - LOLD TO	W The same of the				Dec	576	~		7/2	100		
		1 John 1 - 1	<i>Y</i>								14	77		
İ		30. Name and address of person who			a) (Type,	Print)			-	0				
		RONALD P. T	RHUITZ	MO	560	R	were	usle	DE	2 DALI	SBUR	YMI	S	180-
Sta	ite	31. Date filed (Month, Day, Year)		rer's Signature	4		ba	1		2 SALI				

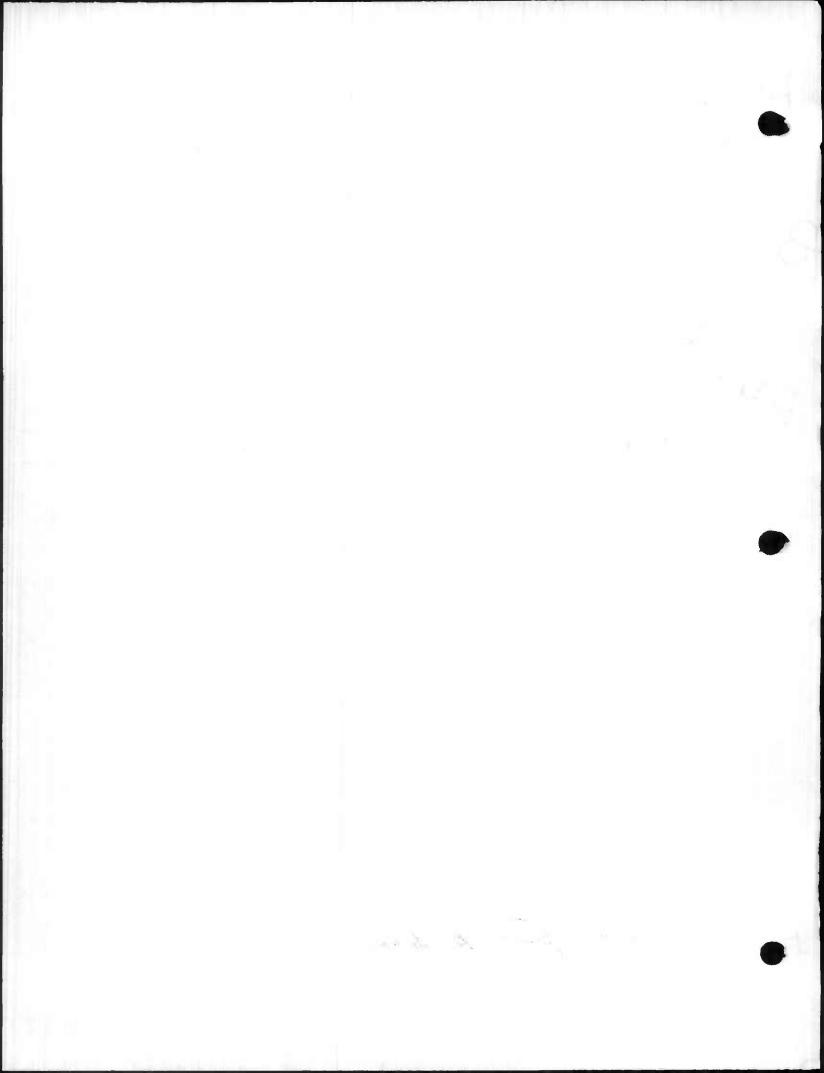


GREGORIO N 31. DATE FILED (Morth, Day, Year) JUL 6 1999

		1 - FOR STATE REGISTRAR		STATE OF N	MARYL	AND / CE	DEPAR	TMENT OF	F H DF	EALTH AND DEATH	MENTAL	HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, M		ANNE							2. DATE O	F DEATH D	AY	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	- 1	5. SEX	6. AGE	PUS (In yrs. last		IF UNDER 1 YEA	Aft	IF UNDER 24 HRS.	7. DATE OF		1	999 8. BIRTH	PLACE (State or Foreign
_		220-09-6615		1 - M 2 KF		86	YRS.	MONTHS DAY	VB.	HOURS MIN.	(Month, 05/14	Day, Year)	,	Countr	y)
pinous		9a. FACILITY NAME (If not instit	tution, give stre	et and number)	,	00		9b. CITY, TOV	MDL O	PR LOCATION OF DE			9c. COUN		YLAND EATH
1, 2, 3	RECTOR	Manokin Mo	100 M	main 1	ton	e		11974	88		Terrace		50	me	rset
Sales	E		10b. COUNTY				10c. CIT	Y, TOWN DR LO	OCAT	ION	_				10d. INSIDE CITY
ii,	D I	MARYLAND 100. STREET AND NUMBER	SOMERS	SET			<u>PR</u>	INCESS							1 YES 2 NO
DZU physician. burlai-transit permit. Pages	FUNERAL		T T.						101.	ZIP CODE			10g. CITE	EN OF W	HAT COUNTRY?
cian.	2	11974 EDGEH		HRAUE 12. WAS DECEDENT	T EVER II	N U.S. ARI	MED	13. WMS	DEC	21853 ENDENT OF HISPAI	NIC OBIGINS	(Specify Ver		American Indian,	
		1 Never Married 2 Mi	arried	FORCES? 1 IF YES, GIVE W	YES	2 N		If yes	6, SP4	2 NO Specif	in, Puerto Ric	an, etc.)	101 NO -	Black	, White, etc.
onding as the	ВУ	3 Widowed 4 Divorce	pd								,		Specify: WHITE		
afte USe	E		DENT'S EDUCA			(G/	ve kind of a	USUAL OCCUP	PATIO g mos	N st of working	16b, K	IND OF BU	SINESS/IND		
	LET	Elementary/Secondary (0-12	2)	College (1-4 or 5 +)		Do NOT us								
he hospit detached once.	COMPL	17. FATHER'S NAME (First, Midd	die Leel		_	HUU	SEWI	<u> </u>	-	16. MOTHER'S NA		WN_HO			
3 % E	BE	ISAAC PEACOC								9 1 22 1 2 1 2 1 2 1 2 1			Sumame)		
retained 5 should notified		19a. INFORMANT'S NAME (Type				198	LENA BRITTINGHAM 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
e feta e 5 si noti	일	FRANCES PUSE	Y/SON				30472 PINE KNOLL DRIVE, PRINCESS ANNE,								ID. 21853
may be		20a. METHOD OF DISPOSITION		al tanan State	20b	. PLACE A	ND DATE	OF DISPOSITION	N (Nai	me of	DATE 20c. LOCATION — City or Town, State				
Page 6 ma al director, I		4 Donatton 5 Other (S)	Specify)		°S	ÄĽTS	BURY	CREMA	TO	RY	7/6/9	9 SAL	ISBU	RY,	MARYLAND
- 4		21. SIGNATURE OF FUNERAL S	SERVICE LICE	NSEE			22. NAME AND ADDRESS OF FACILITY HINMAN FUNERAL HOME								
		MO0295 11673 SOMERSET AVE., PRINCESS AND 23. BART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest,												INF MD	
SE SE		23. BART I. Enter the dise	sases, or co	mplications that st only one cou	cause	d the de	eth. Do r	ot enter the	mod	de of dying, suc	h aa cardia	c or reapi	ratory arre	eat,	Approximate
filled in on, or re		MMEDIATE CAUSE (Final		(2)			9			/	_				Interval Between Onset and Death
		disease or condition a. End Stage Souch Demontra, Vascular Type DUE TO (ORAS A CONSEDUENCE OF): Colvanced Cerebrovascular Disease										-	5 4ks		
8 5 - 6		DUE TO (OR AS A CONSEDUENCE OF):													
ज़ हैं हैं	ON	Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF):											5 yrs		
ficate be en physician a ne prior to	CATION	if any, leading to immedia cause. Enter UNDERLYING		DOE 10	CONSEC	DENCE OF	7):								
phy phy		CAUSE (Disease or injury that initiated events		DUE TO	CONSED	UENCE O	F):						<u> </u>		
. 5 BE #	ERTIFI	resulting in death) LAST	d.												
0 0 0 0	0	PART II. Other algnificant	conditions	contributing to	death h	ut not r	aultina i	in the underly	luimo	anna aluia la	Dord I a	4e. WAS AN	ALITERATION	1	
	CAL	Asterios						escul			10	PERFOR	MED?	246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
requires tequires to the signer of Health	MEDI	Garlines	asha	2008 h	1.0	Pine	D	10000	. /	Prome	1	YES 2	NO NO		OF DEATH?
> 0 0		DID TOBACCO USE	CONTR	BUTE TO CAL	USE O	F DEAT	TH YE	S NO		UNCERTAIL	N D				1 TES 2 NO
2 Pass e	NAI	25. WAS CASE REFERRED TO B	MEDICAL					TH (Check only o							
	rsici	1 YES 2 NO		HOSPITAL:	ER/Outp	patient 3	□ DOA	OTHER:	Home	5 Realdence	8 Other (Specify)			
PHYSICIAN: this certific with the St rked, or it	PHY	27. MANNER OF DEATH 1- Natural 5 Pe	2421	28a. DATE OF (Month, Da			28b. TIM INJ	E OF 28c.	. INJL	JRY AT RK?	28d. DESCI	RIBE HOW I	NJURY OCC	URED	
	ВУ		restigation							ES 2 ND					
ATTENDING ECTOR; After s after death	8		ould not be termined	28e. PLACE Of building,	etc. (Spec	— At hor	ne, ferm, s	street, factory, o	office		281. LOCAT City or	ION (Street a Town, State)	and Number	or Rural A	oute Number,
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	4		- 341120						_						
로로	COMPL	(Check only								and place, and due					
HOSPITAL FUNERAL WITHIN 72	8			On the pasts of ex	aminatio	m end/or ir	rvestigatio	n, in my opinio	on, de			d place, an	d due to the	Cause(s)	and manner as stated.
를 볼 를	BE	296. SIGNATURE AND TITLE OF	CERTIFIER	Bine)	7			29c. LICENSE NUI			29d, DATE	SIGNED	(Month, Dwy, Ybar)
P P 2 %	2	30, NAME AND ADDRESS OF P	ERSON WHO	COMPLETED CAUSE	E OF DE	ATH OTEN	M.	V.	_	D295	05		7	- 5	- 99

5302 CHINABGRRY DR.,

GALISBURY.



RE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

99-4210-015	riease Type
TOUR	State

IN						S	State	e of	Mar	yland /	Department of Health a	and Mental Hyg	iene q q 2	3940
ED_SR.	AMEND	ITEMS:	#23 P	PART	I,	II,	27	PER	MEO	G773	Certificate of Death		eg. No.	0 740
Divini		. Decedent's I	Veme (Fir	rst, Midd	de, L	nst)						2. Date of Deat Month	h Day Yeer	3. Tima of Deati
Physic /Med		JOHN	FR	EDE	RI	CK		REE	D	SR.		JULY		8:44P.M.
Evam		Facility Nan	ne (If not	institutio	on, gh	ve stre	et and	d numb	er)		4b. City, To	wn, or Location of Death	4c. County of Death	

Funeral Director

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Pages 1 and 2 should be finent of Health and Mental Purt: If Itam 27 Is marked of

other

other

6 pemit. Page Department of Important: If any Injury or once.

Physician

/Medical Examiner

physician and s the burial-trans

88 USB Examiner

Physician/Medical

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Completed

the Medical Examiner

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death

filed within 72 hours after

21215-0020

Maryland

Baltimore,

Director

Funeral

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Completed

Be

11. Maritel Status

Examiner

UNION HOSPITAL OF ELKTON CECIL COUNTY **FLKTON** ar | If Under 24 Hrs. | 8. Dete of Birth
ys | Hours | Min. | June | 8 If Under 1 Ye 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 120 M 20 F Months 1936 63 Yrs. 215-34-0009 Pennsylvania **Usual Residence of Decedent**

10f. Zip Code

10a. State 10b. County 10c. City. Town or Location MD. Cecil

College (1-4or 5+)

10d. Inside City Limits 1 ☐ Yes 2 No Warwick

10e. Street and Number 559 Buckworth Rd.

1 Never Married 2 Merried

21912 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 2 Yes 2 No
If Yes, Give
Year or Dates: 59-61 1 Yes 2 No Specify:

14. Rece - American Indian. Bleck, White, etc. Specify: White

eath

3 Widowed 4 NDivorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Yacht Painter

16h Kind of Business/Industry

Marine

10g. Citizen of What Country?

U.S.A.

17. Father's Name (First, Middle, Last)

Irby G. Reed Sr.

Violet Newton

18. Mother's Name (First, Middle, Maiden Sumame)

19a. Informant's Name/Relationship (Type, Print)

21. Signature of Funeral Service Licensee

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)

Kevin Reed 20a. Method of Disposition

11

559 Buckworth Rd. Warwick, MD. 21912 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, Steta

1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

St. Paul's Cemetery 7-23-99 Earleville, MD. 22. Name and Address of Facility

Galena Funeral Home of Stephen Schaech

M00510

118 West Cross St. Galena, MD. Part I into the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one cause on each line.

21635 Approximete Intervel Between Onset and Death

Immedieta Cause (Finat diseese or condition resulting in death)

SEIZURE DISORDER ASSOCIATED WITH ACUTE & CHRONIC ALCOHOLISM

Due to (or as a consequence of):

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events thet initieted events resulting in death) Last

Due to for as a consequence of:

Due to (or as a consequence of):

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE AND ATHEROSCLEROTIC CARDIOVASCULAR DISEASE; CHRONIC

23b. Did tobacco usa contribute time cause of death? 3 Probably 4 Unknown 1 Tyes 2 No

24a. Was an autopsy performed

100 Yes

24b. Were autopsy findings available prior to completion of cause of death2 1 Yes 2□ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient XXER/Outpatient 3 DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 1 No

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of eartifier

29c. License number O.C.M.E.

29d. Dete signed (Month, Day, Year) JULY 19,1999

s of person who completed squise of death (Item 23a) (Type, Print) 30. Name and addre

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) 28

DHMH 16 Rev 6/95

Box 68760, P.O. Records, of Vital Division

20 à peed hes page 2 certificate

The law requires that the death certificate be executed Physician: director. this After Attending

death.

To the Hospital within 24 hours To the Funeral I Hospital

8

s ofter death 176

2

filled in

completely

Be Certification: To funerai

edical

3 Suicide

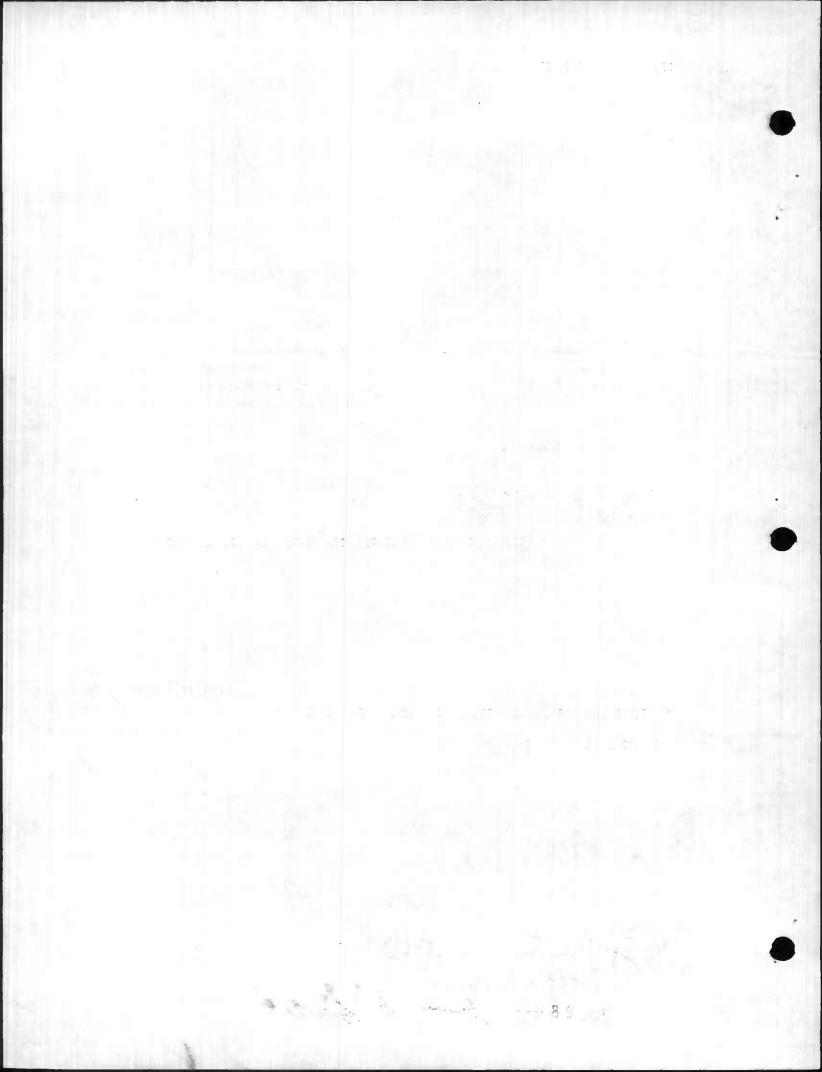
4 Homicide

OBSTRUCTIVE PULMONARY DISEASE

6 Could not be

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restance 32. Registray's Signature



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: 19A PER F.H. G774 8-21-99 WR. Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month, ILIT, Y **Physician** 19 1999 CAROL SPALDING 7:28PM /Medical 4a Facility Name (If not institution, giva street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner LA PLATA CHARLES CIVISTA MEDICAL CENTER if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Aug. 30, 1936 Birthpiace (State or Foreign Country) **Funeral** Months 1 M 200 F Days Hours 220-32-6825 62 Yrs. Director Washington, D.C Usual Residence of Decedent with the Merylend 10a. State 10b County 10c. City. Town or Location 10d Inside City Limits Pages 1 and 2 should be filed within 72 hours after deeth with the Menylen nent of Heelih end Mentel Hyglene. anti of Heelih and Mentel Hyglene. anti if Item 27 is marked other than "natural", or itema 23a or 28a-f ahow ury or other traumatic event, the Medical Examines must be notified at 1 Yes 2 No Maryland Charles Bryantown Director 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 6939 Leonardtown Road 20617 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21216-0020 Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Charles County College (1-4or 5+) Elementary/Secondary (0-12) Teacher's Aid School System 18. Mother's Name (First, Middle, Maidan Sumama) 17. Father's Name (First, Middla, Last) Be Hazel Wheeler George M. Sullivan 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. informant's Name/Relationship (Type, Print) Hoseph B. Spalding/Husband permit. Pages 1 and 2 Department of Heelth e Important: If fem 27 is any injury or other trai 6939 Leonardtown Road, Bryantown, Maryland 20617 20b. Place of Disposition (Nama of 20c. Location - City or Town, State 20a. Method of Disposition emetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Old Fields Cemetery 7-23-1999 Hughesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of paral Service Licen e The Huntt Funeral Home, Inc. BROHAWN MARK G. O. Box 156, Walderf, Maryland 20604 M00053 mew PONTO CEREBELLAR DEGENERATIO Prest and Death Do pot enter the mode of dying, such as cardiac or respiratory arrest, **Physician** RESPIRATORY /Medical Immediate Cause (Final disease or condition resulting in death) Examiner CEREBELLAR DEGENERION Examiner ONTO The law requires that the death certificate be executed ettending physician and for use as the bunal-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed irector, page 2 s TUYES 2 ANO 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. director, 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this 27. Menner of Deeth 28e. Date of injury (Month, Day Yaar) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturai 5 Pending investigation 1 Yes 2 No the Funeral Director: Ampletely filled in by the funeral Director. 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, Steta) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a, Certifier (Check off) within 24

State Registrar 29b Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature Comme JUL 2 1 1999

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)

M.D

G.K. HATOUM M.D. 6620 CRAIN HIGHWAY LA PLATA MARYLAND 20646

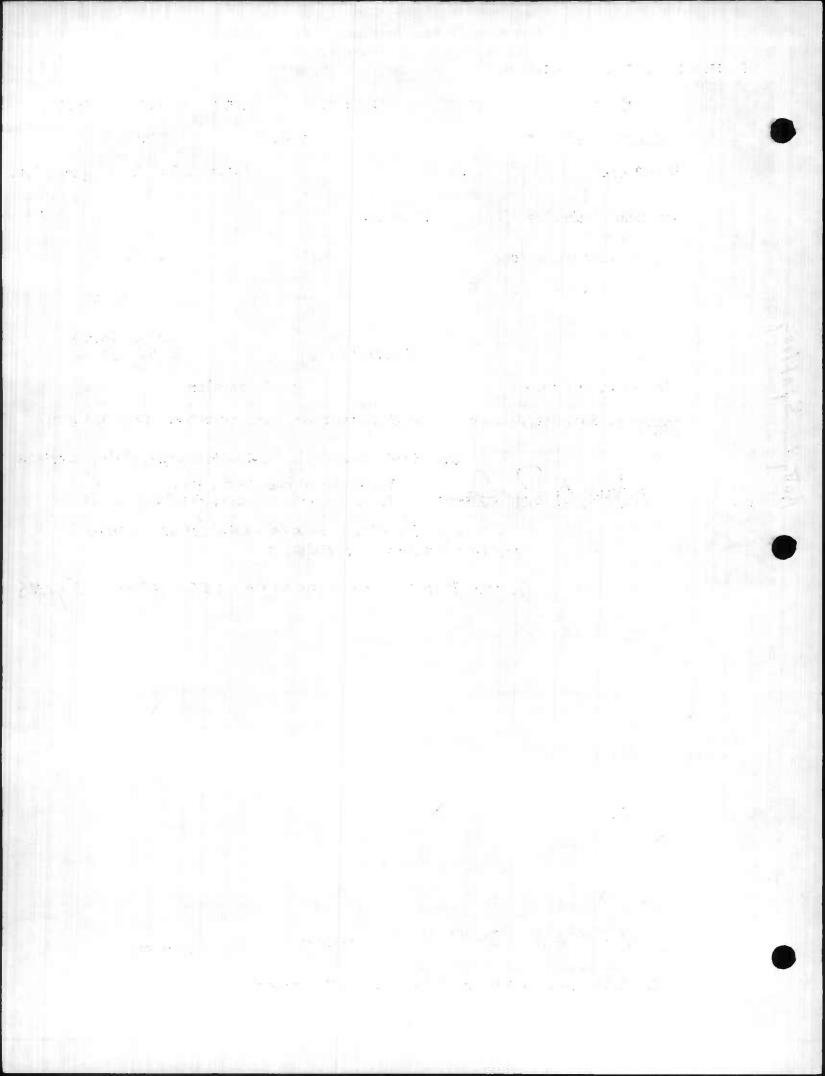


29c. License number

D-32495

29d. Date signed (Month, Day, Year)

7-20-99



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State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death 1. Decedant'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Vear **Physician** PAUL F. TYLER, JR. July 12, 1999 2:51 P.M. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner McCready Memorial Hospital Crisfield Somerset 6. Sex 12 M 2□ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiace (Stata or Foreign Country) **Funeral** 214-68-7484 40 Yrs. Director December 5, 1958 Maryland Usuai Residence of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland Somerset Crisfield 1 ☐ Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 4212 Jacksonville Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyghene.
Important: If Hem 27 is marked other than "natural", or Hema 29-any Injury or other traumatic event, the second 21817 Funeral U.S.A. 14. Race - American Indian, Black, White, atc. 12. Was Dacedant Evar in U.S. Armed Forces? 6.722 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritai Status 1 Nes 2 No 6/22/76 If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working iifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Seafood Waterman 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Paul F. Tyler Luana Helen Simerson 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Bobbi Fae Tyler (Wife) 4212 Jacksonville Rd. - Crisfield, MD 21817 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State American Legion Cemetery 7/15/99 4 ☐ Donation 5 ☐ Other (Specify) Crisfield, MD 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature of Funeral Sarvice Licens Robert H. Bradshaw, Jr. 306 W. Main St.- Crisfield, It 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, euch as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. 306 W. Main St. - Crisfield, MD 21817 Approximate Interval Betw Onsat and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) MYOCARDIAL IN FARCTION /Medicai HP Examiner Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Cause (Disease or Injury that initiated events Due to (or as a consequenca of): Box 68760, Physician/Medical Due to (or as a consequence of). resulting in death) Last Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? DIABETES MELLITES 1 Yes 2 No 3 Probably 4 Unknown þ 24e. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed peed completion of cause of daath? 2 /3 No 1 ☐ Yas 2 No certificate 1 Yes of Attending Physician: ofter death.

Director: After this certifica 25. Was casa reterred to medical 8 26. Piace of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner ot Deeth 1 Natural 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, State) 3 4 Homleide 24 hours e Hospital 1 Certifying Physicfan: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to tha cause(s) end manner stated. 29a. Certifier Medical within 2 To the To the 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D51086 July 12, 1999 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Eshwar Kanchana, M.D. - 320 W. Main St.- Crisfield, MD 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

Sporks

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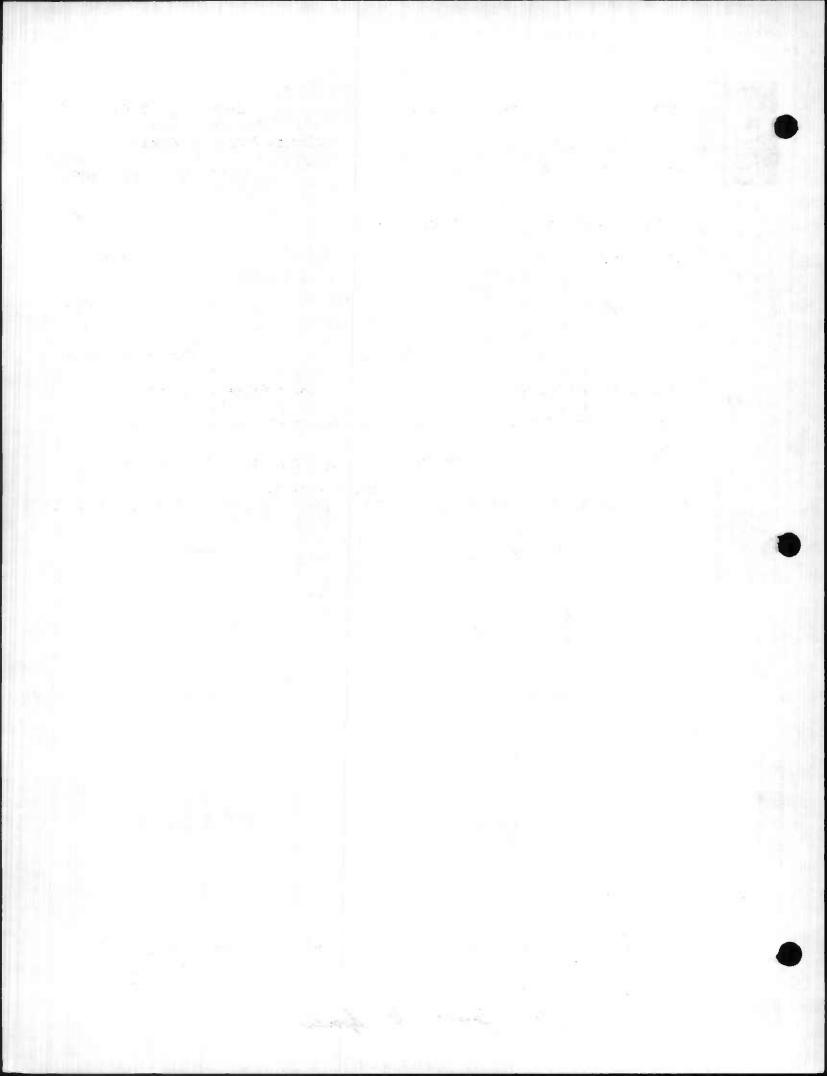
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Day Moath Yaar **Physician** 1999 Rosalie Woodrow 164 10 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner FIX ton

If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Union Hospital 6 Say 9. Birthpiaca (Stata or Foreign 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1□ M 250 F Days 78 September 1, 1920 Director Virginia 168-12-3915 Usual Rasidence of Decedan the Manyland 10d Insida City Limits 10a Stata 10h County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Mapical Examiner must be notified at 1 TYAS 2 TKNO Directo Maryland Cecil Elkton 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 586 Leeds Road United States Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yaa or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Navar Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) in her own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h Fielden Hash Minnie Holoway 19b. Meiling Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health important: If item 27 i Patricia A. Lusby/Great niece P.O. Box 216, Pomeroy, Pennsylvania 19367 Injury or other Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7/15/99 Leeds, Maryland Leeds Cemetery 21. Signature of Funanti Sarviss Licensee, 22. Nama and Addrass of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 23- Part Priver the disease, or comercations that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** heart failure /Medical immediata Causa (Final · congestive disaasa or condition rasulting in daath) Examiner Examiner pneumonia physicien and the burial-transit Saquentially list conditions, if any, laeding to immediata cause. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) P.O. Box 68760. Physician/Medicai Dua to (or as a consequence of): ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceusa givan in Part I. 23b. Did tobacco use contribute to the cause of death? gastrointestinal hemonphage 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed I Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed anorexia page 2 1 Tes 20 No CVA 1 ☐ Yes 2 BaNo Division of Vital Hospital or Attending Physician:
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth July **Physician** 8, Mildred 1999 9:50PM /Medical 4a Facility Neme (if not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Laurelwood Nursing Home Elkton Cecil 8. Date of Birth (Month, Dey, Year) Aug. 22, 1920 5. Sociai Security Number 6 Sax If Under 24 Hrs. Birthplace (Steta or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1DM 2EF Months Deys Hours 233-20-3543 78 Yrs. West Virgin Director Usual Rasidance of Decedan the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic evant, the Mildical Examinar must be notified at 1 Yes 2 No Director MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic evant, the Medical Examiner must bonce. 100 Laurel Drive 21922 USA Funeral 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yas Tho Specify: Saltimore, Maryland 21215-0020 py 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) A & P Super Market cashier 12 18. Mother's Name (First, Middle, Meiden Sumema) 17. Father's Name (First, Middle, Last) Andrew Mercer Cora Mae Mitchell 19b. Meiling Address (Straet and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Nama/Reletionship (Type, Print) Francis L. Cool (Daughter) 2609 Lamper Lane Wilm., DE 20b. Place of Disposition (Neme of cemetery, crematory or other piece) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata Silverbrook Crematory 4 □ Donefion 5 □ Other (Specify) 7/15/99 Wilm., DE 21. Signature of Fundry Service Licensia /// 22. Name and Address of Fecility McCrery Funeral Homes, Inc. Wilm., DE 3924 Concord Pike 19803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Approximate intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in daath) /Medical Myocasdial Infarction
Dua to (or es a consequence of): HOURS Examiner Examiner Coronary Artery
Due to (or as e consequence of): Disense physician and the bural-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury fhet initiated events rasulting in death) Last the death certificate be exec Chronic Obstructive Pulmonury Disease Physician/Medical Due to (or es e consequence of) 98 Hypertension USe 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 Yes 2 100 1 Yes 2 No certificate Hospital or Attanding Physician: 24 hours eftar deeth. Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidenca 8 Other (Specify) 1 Yes 2 No 2 funeral 27. Manne of Deeth 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the P within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signatura and fitla of certifier 29c. License number MD July 9, 1999 D0047711 30. Name and addressed or an who completed cause of deeth (Item 23a) (Type, Print) North East Maryland 21901

Mouldin Avenue

3

32. Registrer's Signature

DHMH 16 Rev 6/95

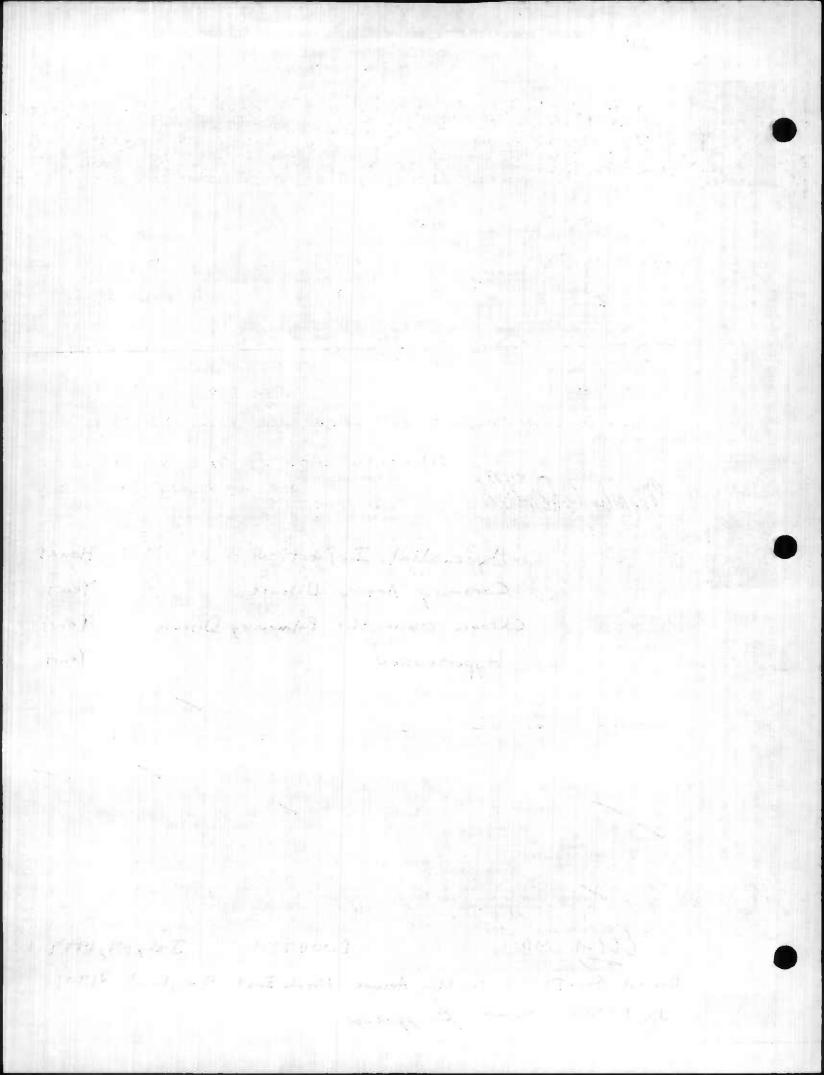
State

Registrar

David Gar-El

31. Data filed (Month, Day, Yeer)

JUL 1 4 1999



Plea

	Please	Type or Pr								egible	
		State of M	Maryland / I		irtment of I <i>tificate of</i>		rug v	-	rgiene Reg. No.	99	23946
1. Decedent's Nam	ne (First, Middle, La	ist)						2. Dete of De		Vas	3. Time of Death
	Alfr	ed Charle	s Wein					JULY 1	.5, 19	999 Yea	3:00 AM
4a Facility Name (If not institution, giv	ve street end numbe	ar)			4b. City, To	wn, or L	ocation of Deeth		County of De	
1281 CEI	DAR CORNE	R ROAD				PERRY	ZVIL	LE	C	CECIL	
5. Social Security N 071-16-1	Number 6. S	-	Age (In yrs. last bi	Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birt (Month, Da May 6,	1920	9. B	Birthplace (State or Foreign Country) ew Jersey
Usuel Residence of	1		I sa- Ohu Ta	Lev							The state of the s
10a. State	10b. County	• •	10c. City, Tow	/n or Loca							10d. Inside City Limits
Maryland		cil			T	ryvill	.e				
10e. Street and Nu					10f. Zip Code				10g. Citize	en of What (
1281 Ced	dar Corne	,			1	1903				U.S	
11. Marilal Status		12. Was Deceder	s?	13. W	Ves Decedent of Yes, specify Cub	Hispanic Original Control	gin? (Sp	pecify Yes or No o Rican, etc.))- 1·	4. Raca - An Black, Wi	merican Indien, hite, etc.
1 Never Marr	ried 2 Married 4 □ Divorced	MXYes 2 If Yes, Give Yeer or Detes	□ No	10	□ Yes ŽŒNo				5	Specify:	White
(Spec	15. Decedent's Ed	ducation ade completed)	168	(Give ki	ent's Usuel Occu kind of work done	during most	t of worl	kina	16b. Kin	d of Businer	ss/Industry Ctric Company
Elementery/Seco	ondary (0-12)	College (1-40) Four Yea		life. Do	Owner	ed)			Nort	h East	t, Maryland
	(First, Middle, Last, Alfred C	. Wein, S	r.			18. Mothe	r's Nam	ne (First, Middle, Rose	Clar		
	ame/Relationship ((Type, Print)	198		g Address (Stree			ral Route Numb	ber, City or	Town, State	yland 21903
4 Donation 21. Signewre of Fu	5 ☐ Other (Specification of the service Licer	ensper Little	St.	Mark Le Pe	natory or other place is Ceme Neme and Address Pacerry ville	tery ress of Facilit tterso e. Mar	on &	Son Fun	neral 03-01	Home	e, Maryland
23a. Part1. Enter t shock, or hee Immediate Cause disease or condition resulting in death)	(Finel	nplical ons that cause on each	sed the death. Do h line. INOMATOS Due to (or as a	IS	-15	ng, such as	cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
Sequentially tist co	anditions C	b	Due to (or as a								
if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	mmediate erlying r injury	c									
resulting in death)	Last	d	Due to (or as a	consequ	ence ory:						
Part II. Other signif	licant conditiona c	contributing to death	but not resulting	in the un-	derlying cause g	iven in Pert I			Yes 2		ute to the cause of death? Probably 4 Unknown
									s en autops formed?	sy 24	b. Were autopsy findings aveilable prior to completion of cause of death?
										No	1 ☐ Yes 2 ☐ No
25. Was case refer exeminer?		Hospital:			10	ther.		ath (Check only			
1 ☐ Yes 2 ☒ 27. Menner of Deet 1 ☒ Natural	th 5 Pending		njury 28b.	Outpatient Time of Injury	28c. Inju	ury at ork?		fome 5 💆 Resi 28d. Describe			pecify)
2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	be 28e. Place of I	Injury - At home, fetc. (Specify)	iarm, stre		⊒Yes 2□	No	28f. Location (City or To	(Street and own, State)	1 Number or	Rural Route Number,

Examiner Division of Vital Records, P.O. Box 68760,

been signed by the ettending physician and should be detached for use es the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes I completely filled in by the funeral director, page 2 of

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other treumatic event, the Medical Examiner must be notified at enone.

Physician

/Medical

Baltimore, Maryland 21215-0020

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ALFRED NAME

PHYSICIAN:

2

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Jun

Director

Funeral

Completed by

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To

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

10+1VA

State Registrar

29b. Signature and title of cartifier

29c. License number D27578

29d. Date signed (Month, Day, Year)

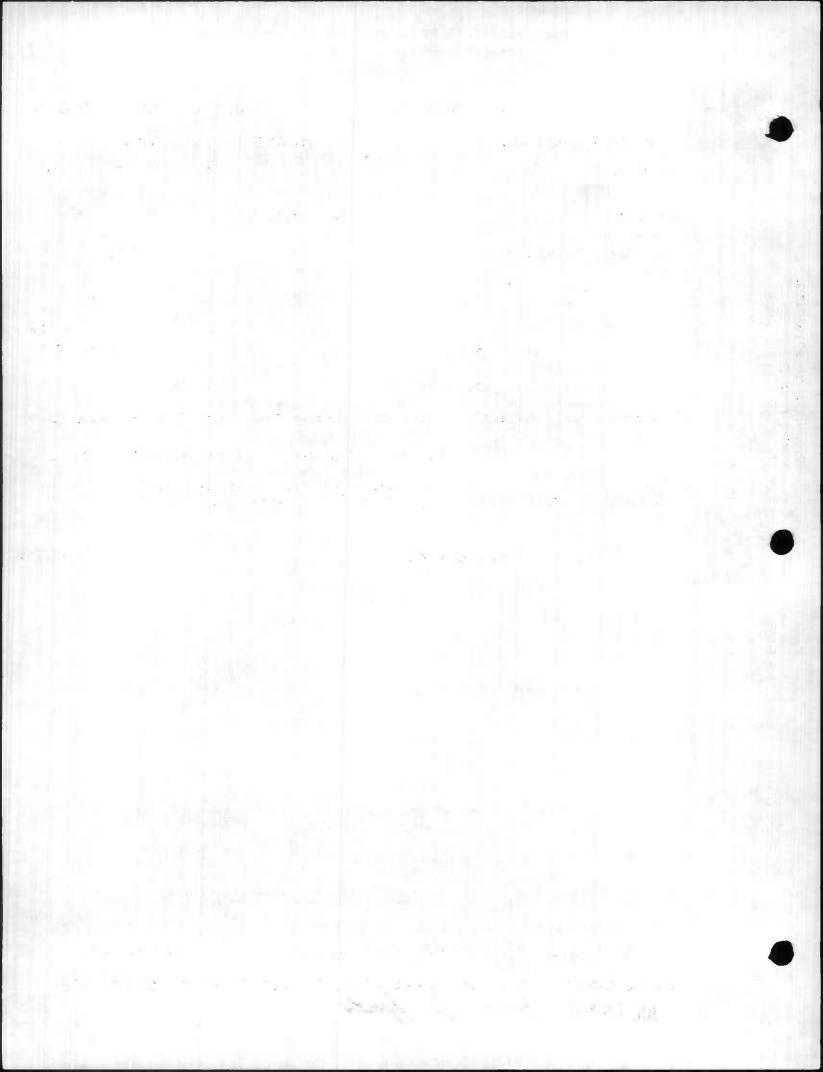
JULY 15, 1999

30. Name and address of person who completed cause of death (Item 22e) (Type, Print)

M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD AVELINA HERNANDEZ, 21902

32. Registrar's Signature 31. Dete filed (Month, Day, Year)

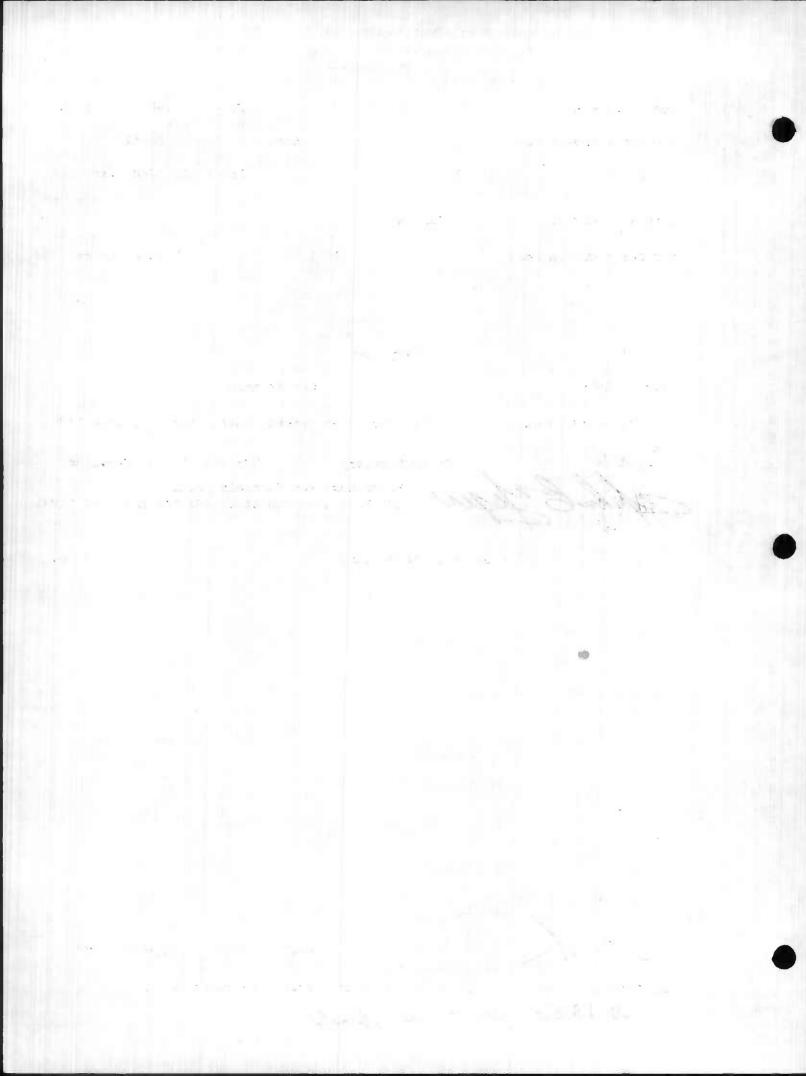
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State of Maryland / Department of Health and Mental Hygiene 99 2391, 7

								Cert	ificat	e of	Death			Reg. h	lo.			
			1. Decedent's Neme (First, Mide	fle, Last)									2. Dete of De	eth			3. Tim	e of Death
	Physicia		Ronald Wright										July 1		^{Эву} 1999	Year	140	15
1	/Medic		4e Facility Neme (If not institution	on, aive s	treet and nu	umber)					4b. City, To	wn, or Lo	cation of Deel		4c. County	of Death	1140	3
1	Examin	ier	810 Union Chu	-/-							-	kton			Ceci			
_			5. Sociei Security Number	6. Sex		7 Aco //r	yrs. last bir	thdoul	If Under	1 Yeer			9 Date of Bi	rth			alana (Ct	ate or Foreign
	Funeral				M 2□F			Yrs.	Months	Deys		Min.	8. Dete of Bi (Month, Di			Соці	ntry)	
	. Director		220-52-5769 Usual Residence of Decedent	1		5	51						March	12,	1948	Vı	rgin	ııa
	and **		10a. Stete 10b. Count	γ		10	c. City, Tow	n or Loca	ation							Ţ,	IOd. Insid	le City Limits
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	E 9 8	5	10e. Street and Number						10f. Zip	C006				10g. (JUZEN OF W	rnat Coul	ntry	
	23 ath v	ra La	810 Union Church Road 21921 Uni									nited						
	72 hours after death with the Maryland natural', or itams 23a or 28e-f ahow deal Exam har must be notified at	by Funeral Director	11. Meritei Stetus		2. Wes Dec Armed F	orces?	r in U,S.	13. W	es Dece Yes, spe	dent of I cify Cub	Hispenic Ori en, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	0-		e - Americ k, White,	can indie etc.	n,
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7	w be	Son	11				С	arpe	enter									
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and	arin arin		19e. Informent's Neme/Reletion	ship (Ty)	oe, Print)		19b	. Meiling	Address	S (Stree	t and Numb	er or Run	al Route Numl	oer, City	y or Town,	Stata, Zip	Code)	
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f ahow any Injury or other traumatic avant, the Medical Examinar must be notified at pine.						Union			-	acc of Earili		/1//99	Ur	ion,	mary	Tanc	L
Ba	Depa mpo any li		4 □ Donetion 5 □ Other (Specify) Union Cemetery 7/17/99 Union, Ma 21. Signature of Fun and Septice Lice 22. Name end Address of Fecility Hicks Home for Funerals, P.A.															
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	Hospital or Attending 24 hours after death. Funeral Director: After staly filled in by the fune		29a. Certifier 1 X Certify	na Phys	ician: To the	e best of m	v knowledge	a. death o	occurred	at the t	ime, date ar	nd place.	and due to the	CAUSE	(s) and ma	nner as s	stated.	
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical			er: On the t		amination an						red at the time					150(s)
	Vithin 2 To the	Me	29b. Signeture end title of certific	er /					29	c. Licen	se number			29d. l	Date signed	d (Month,	Day, Ye	ar)
	FIFE		11.	1									Į					
			100	1							D441	.02			July 1	15,	1999	
	8		30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)															
	U		Wm. Renzulli,					rtor	n Ro	ad,	Elkto	n, M	arylan	1 2	1921			
	Sta	_	31. Dete filed (Month, Day, Year JUL 16	1999		Registrer's	Signeture	4	1									
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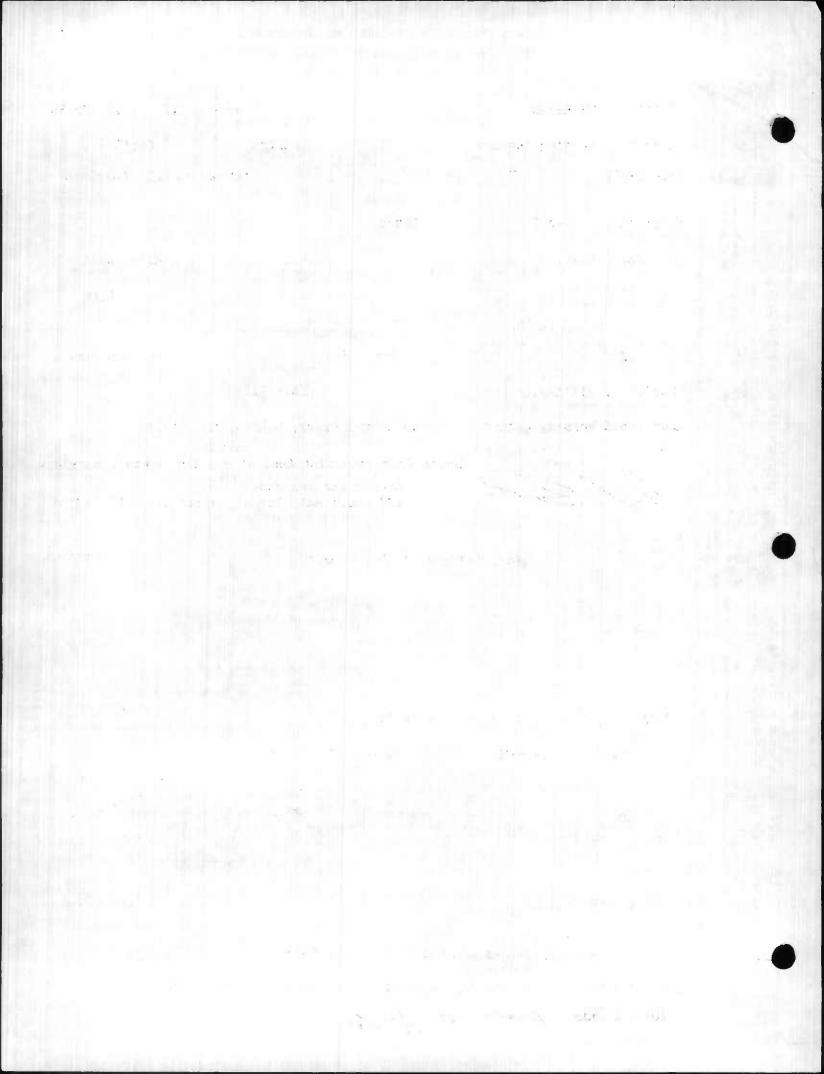


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State of Maryland / Department of Health and Mental Hygiene 99

e 99 23948

				Cert	ificate of	f Death		Reg. No.				
Newston	1. Decedant's Nama (First, Midd	a, Last)					2. Data of I Month	Daath Day	Year	3. Time of Death		
ysician Jedical	EDITH WILI	IAMS					July	17	1999	09:35		
aminer	4a Facility Nama (If not Institution	, giva street and number	r)			4b. City, Town	n, or Location of De	ath 4c. Co	unty of Death			
	Laurelwood Nurs	ing Center				E1k	ton		Cecil			
ral	5. Social Security Number	6. Sax 7. A	iga (In yrs. last bi	rthday)	If Undar 1 Yas	ar if Undar 24				place (Stata or Foreign ntry)		
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Director	10e. Street and Number				10f. Zip Coda			10g. Citizen of What Countri				
	100 Laurel Driv					21921		TTen	****			
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Be									,,,,,,			
To	Charles L. Wil:						Life	1 01 00	0 7.			
	19a. Informant's Name/Ralation						or Rural Routa Nun		own, Stata, Zij	5 (009)		
	Laurelwood Nurs	ing Center				rive, E	1kton, MI					
	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation	3 Removed from Stat	comete	ry, crama	ition (Nama of atory or othar p	lace)	July 20		ion - City or T	own, Stata		
	4 Donation 5 Othar (S			North East Methodist Cem. 1999 North East, Mar								
e e	21. Signature of Funaral Surfica	Ucene		rass of Facility								
900	11/2/14/			neral H			MD	21001				
	23a Part1 Enter the disease of	complications that caus	ad the death. Do	not anter	/ South	Main S	treet, No	errast	st, MD	21901 Approximata		
	23a. Part1. Entar tha disaasa, o shock, or haart failura. Lis	only one cause on each	lina.			,,				Intarval Between Onsat and Death		
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7			Due to (or as a	consaqu	anca of):							
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2	Part II. Other significant conditi	ons contributing to death	but not rasulting	in tha und	darlying causa	givan in Part i.	23b. D	ld tobacco us	e contribute t	to the cause of death?		
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Certification:												
	29a. Certifiar Certifyl	g Physician: To the bes	t of my knowledg	e, daath d	occurred at tha	tima, data and	place, and dua to ti	he cause(s) an	d mannar as	atated.		
edical	(Check only 52 Medical one)	Examiner: On the basis and manner	of axamination as stated.	nd/or inva	astigation, in m	y opinion, daath	occurred at tha tim	a, data and pla	ace, and dua	to the cause(s)		
Me	29b. Signatura and title of certific	r			29c. Lica	insa number		29d. Data s	igned (Month	, Day, Year)		
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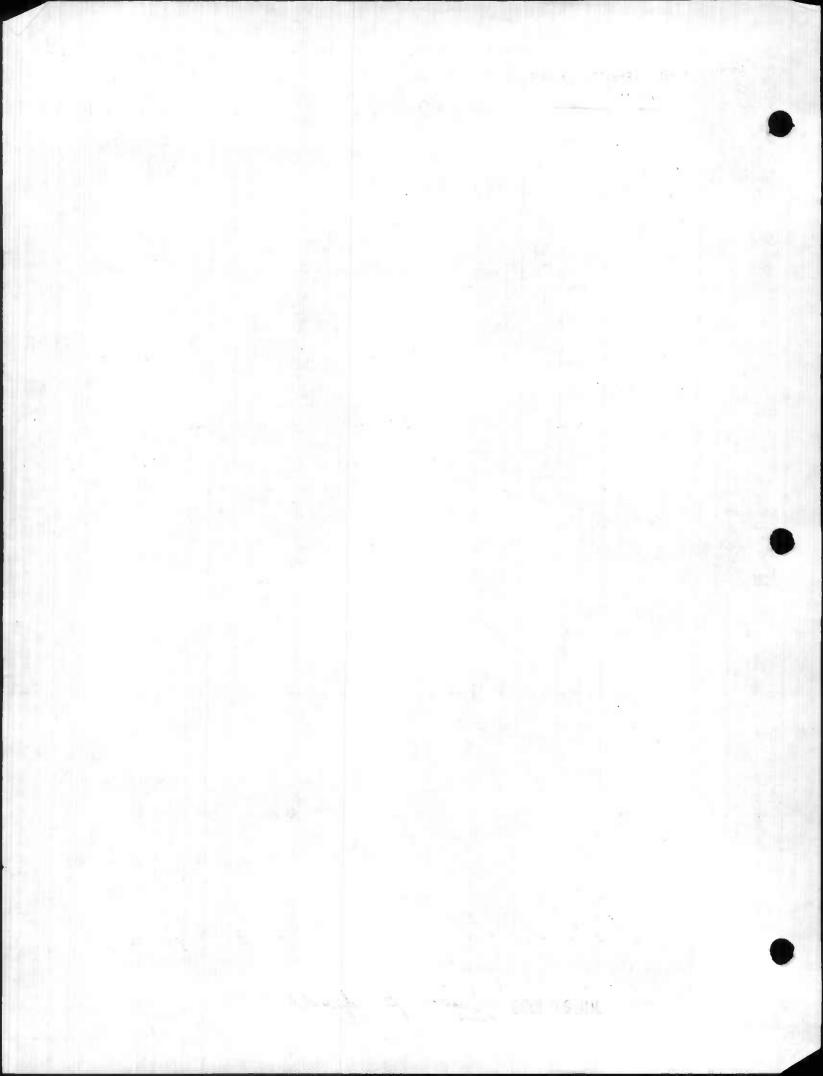
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Amended item#1 perPhyG774 8/3/99 EW

1. Decedent's Nama (First, Middla, Last) Certificate of Death 2. Date of Death 3. Time of Death Everette Month **Physician** 29 10:15AM July AUSTON 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Stella Maris Nursing Center Towson Baltimore 8. Date of Birth (Month, Day, Year) June 29, 19 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (Stata or Foreign Country) **Funeral** Months Hours 10(M 20 F Days Yrs. 250-52-0440 1933 66 Director Tennessee Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location r 28a-f ahow notified at 10d. Inside City Limits 1 Yes 2 No MD. Harkord Pulesville Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23s or must be 1614 Scott Road U.S.A. 21132 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Statue 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, atc. Armed Poless:
1 [X] Yes 2 [No
If Yes, Give
Year or Dates: Korea after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: Specify: à 72 hours 3 Widowed 4 Divorced White natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Corrections Officer 12th grade Baltimore City Jail other ! permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othr any Injury or other traumatic avent potas. 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Evert Austin Hazel Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Doris Jean Austin (Wife) 1614 Scott Road. Pylesville, MD. 21132 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Marylana Green Mount Crematory 7/31/99 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimuneh Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** V3266 8 61583.2 /Medical Immediata Ceusa (Final disease or condition rasulting in death) Examiner Due to (or as a consequence of): Examine be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, edical Due to (or as a consequence of): 88 Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. P.O. 23b. Did tobacco use contribute to the cause of death? 94 301500 1 Yaa 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No certificata Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4Nursing Homa 5 Residence 6 Other (Specify) 0 1 Yes 25 No this in 24 hours after death.

• Funeral Director: After th.

• Funeral Director: After th. 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 □ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the Vithin 2 of conflict 29b. Signatura 29d. Date signed (Month, Day, Year) 7.29.68 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, MD. 2300 Dulaney Valley Road. Towson, MD. 31. Data filed (Month, Dyures 0 1999 32. Registrar's Sign State Registrar DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 7 3 9 5 0 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month CARL ANSON 2.00 AM July /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Sinai Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociei Security Number **Funeral** Birthplece (Stete or Foreign Country) Months Deys 1□ M 2□ F 71 Yrs. Director 215-28-5734 May 5, 1928 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumstic event, the Medical Examiner must be notified at Director 1 √ Yes 2 No Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ itams 23a 700 W. 40th Street 21211 U.S.A. Funeral death 12. Wes Decedent Ever in U,S.
Armed Forces unknown
1 □ Yes 2 □ No
If Yes, Give
Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural" or itan any injury or other traumatic event, its Medical Examines. Bieck, White, etc. 1 S Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Social Security Elementery/Secondary (0-12) Cotlege (1-4or 5+) 5+ Adjudication Officer Administration 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Karl G. Johanson Anna Viktoria Forsberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Alexander R. Martick/executor 1500 Court Sq., 200 E. Lexington St., Balto., MD 21202 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Other (Specify) in state 21. Signeture of Fune Mi Servica Licansee 22. Name end Address of Fecility Ronald St Wid Director State Anatomy Board, 655 W.

Baltimore, MD 21201

Ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, lock, or heart feiture. List only one cause on each line. Director State Anatomy Board, 655 W. Baltimore Street Approximate Interval Between Onset end Death **Physician** e. Triple wessel Coronary ordery Obsease /Medical Immediate Cause (Final unknown diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed physician and s the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): P.O. Box 68760. Physician/Medical resulting in death) Last Due to (or as a consequence of) ate hes been signed by the a page 2 should be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown artic stenosis Records, Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? intestinal Alad of unpusion 24a. Wes en eutopsy performed? dugen certificate 1 Yes 2 17 No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending Investigetion 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29e. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete end placa, and due to the ceuse(s) end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) TIME GREGOR, LESWICK, 700 W. 40 th STREET, BALTIOTORE, MD 2 W.11 17 BABELLE 32 Registrar's Signeture 31. Dete filed (Month, Day, Year) State

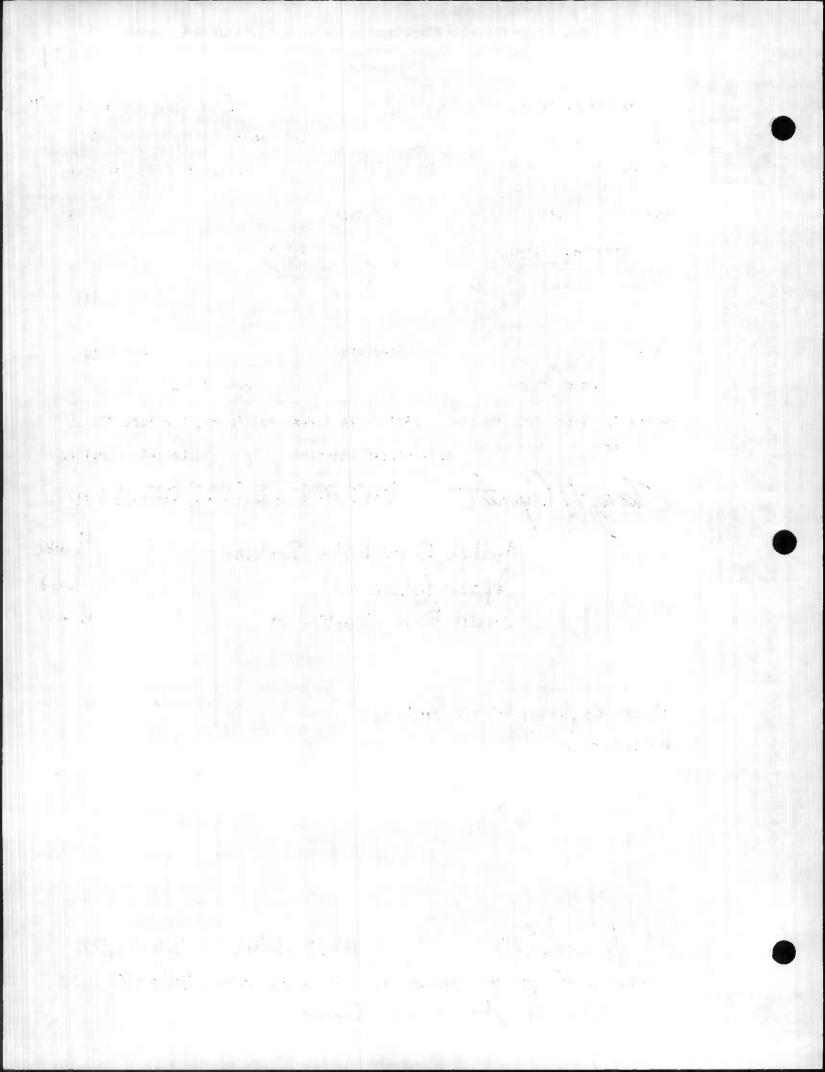
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of Haalth Hem 27 I	20a. Method of Disposition		20b. Plec	e of Disposition (Ne etery, crematory or	me of	ce)	Dete	20c. Location -	City or Town	n, State
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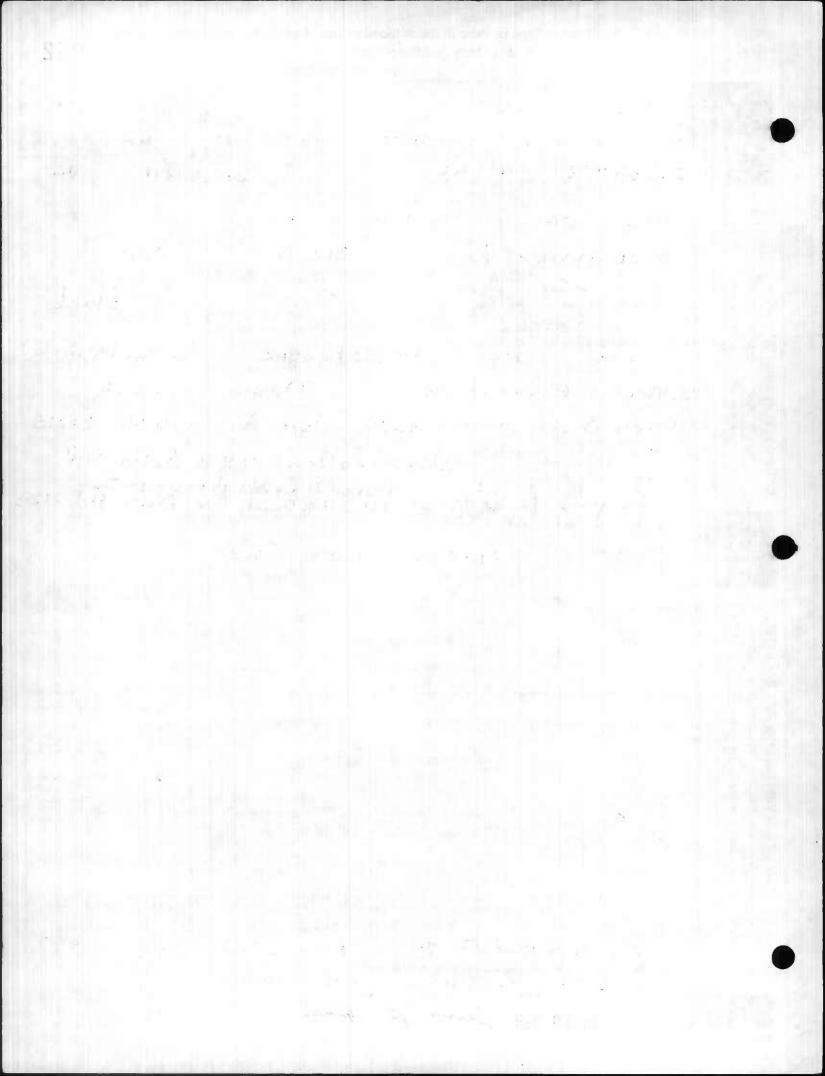


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** Theresa Blowe 1999 11:45am 4b. City, Town, or Location of Death 24 /Medical 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** 1 M 200F Months 223-60-1792 Yrs. June 6 1941 Director Usuel Residence of Decedent with the Maryland r 28a-f show inotified at 10e Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits Baltimore 1 Yes 2 No Director NA WP 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or : traumatic avent, the Medical Exercitors must be r MZA 21200 pemili. Peges 1 and 2 should be lied within 72 hours effer death v. Department of Health and Menial Hygiene. Important: if item 27 is marked other than 'natural', or items 28a appla. 3921 Maine No e Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, 11. Maritei Stetus Bleck, White, etc. 1 Never Married 2 Married B 1 Yes 2 No Specify: If Yes, Give Yeer or Detes: P 3 ☐ Widowed 4 ☐ Divorced lac 16s. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Sinai 12+h EEDER NA 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Jarie EVERSON JARENCE E. JOOH 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Ave. 10 4205 Delvies 1-10 21215 Marie Scott-mother 20b. Plece of Disposition (Name of cemetery, cremetory or other p Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 Burtel 2 □ Cremetion 3 □ Removel from State ood laws Cem 7.30 99 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reshock for heart failure. List only one cause on each line. tome u Balto Ave. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel Metastatic Breast Concer 19 years diseese or condition resulting in death) Examiner Due to (or es e consequence of) Examiner that the death certificate be executed attending physician and for use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated avents resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): 88 23b. Did tobacco use contribute to the cause of death? P.0. Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. and the 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detac Records, p The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy has page 1 Yes 2 XNo 1 Yes 200 No certificata Division of Vital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1 Yes 20 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Neturei death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner stated. edical 29e. Certifier completely (Check only one) 29b. Signeture and title of certifier 29c. License number 29d, Date signed (Month, Dev. Year) Naren L. Babitt 24, 1999 RES 000 July 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Karen Babitt Sinai Hospital of Baltimore 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture

State Registrar

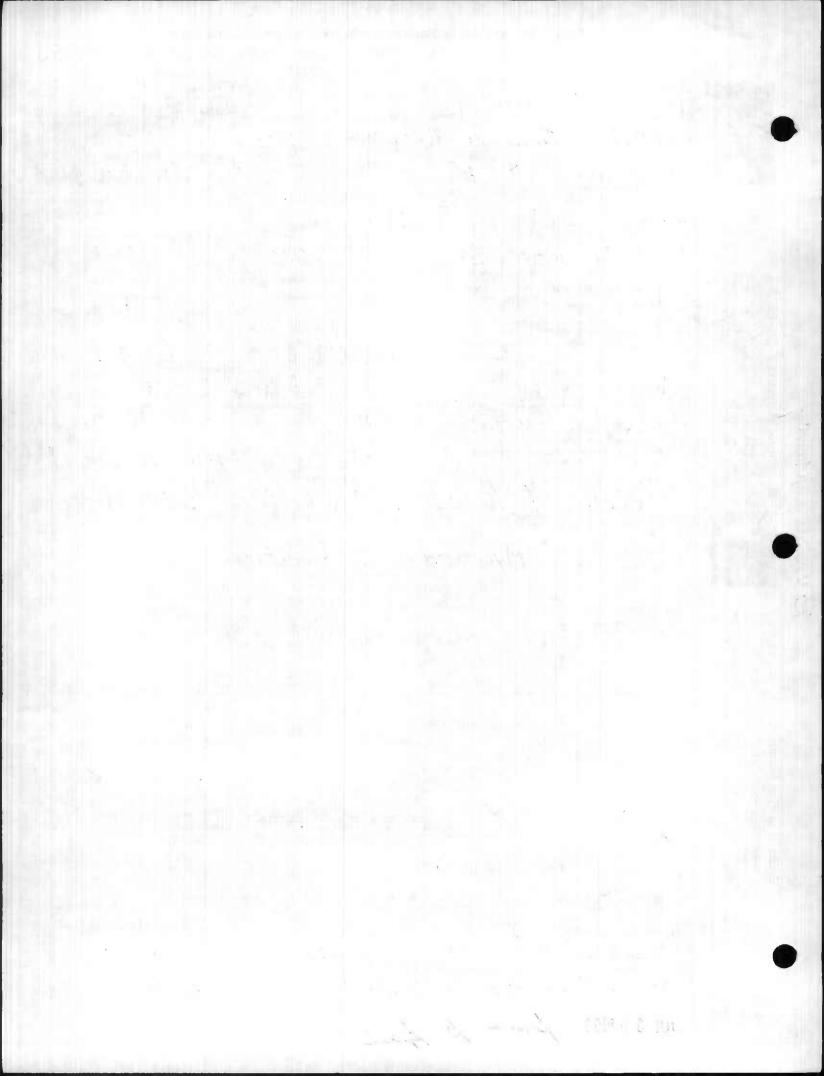
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day, 1999 24, 1999 4c. County of Death **Physician** /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) Examiner MARYLand CIT HOSPITAL BALtimor GENERAL If Under 24 Hrs. 8. Dete of Birth Hours | Min. | Month, Dev 5. Social Security Number 7. Age (In yrs. last birthday) (Stete or Foreign **Funeral** 1□M 20F Deys 216-34-7148 Usuel Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Haatih and Mental Hygiena "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic avent, the Modical Examinar must be notified as 1 XYes 2 No 10e. Street and Number Director mor 10g. Citizen of What Country? 10f. Zip Code 2 21 a Funeral 00 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritei Stetus 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. 1 þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. PO NOT use retired) 16b. Kind of Busi ess/Industr Elementery/Secondary (0-12) College (1-4or 5+) el 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 (dayighter 19e. Informent's Neme/Reletionship (Type, 19b. Malling Address (Street end Number or Rural Route Number, City or Town, 20b. Plece of Disposition (Name cametery, cremetory or other 0 25 20e. Method of Disposition Important: If it any injury or 1 Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete Department 4 □ Donetion 5 □ Other (Specify) Cemeter 22. Name and Address of Facility
JOSEPH
2222 W. NOT 21. Signutors of Funeral Service License Pe 11 Enter the ciseese, or complice is a sthet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediete Ceuse (Finel diseeze or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Examiner nding physician and usa as the bunel-transit requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Inknown 1 | Yee 2 | No signed t þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy periormed? Completed paga 2 s cartificata has 2 No Hospital or Attanding Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yea 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Aftar this lunaral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth Veturel Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending aftar daath. Director: Aft 2 □ No investigetion 1 TYes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

Leadical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and menner stated. 29a. Certifier Medical complataly (Check only one) To the Vilhin 2 29b. Signeture end title of certifie 29d. Dete signed (Month, Day, Year) 29c. License number Mr. S P0053850 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 0 MARYLAND GENERAL HOSPITAL Teven 0 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar 0 1999

AH!

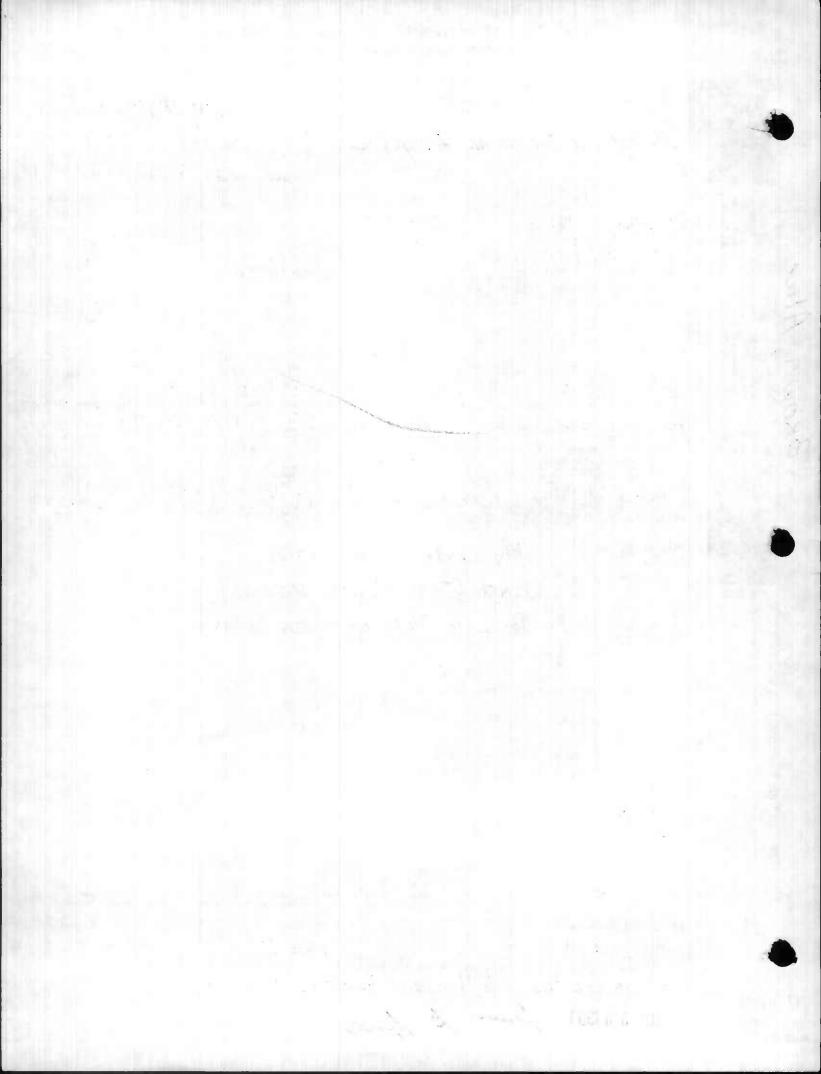


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Degedent's Name (First, Middle, Last) 3. Time of Death **Physician** 0 :00 /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deal 4c. County of Deat Examiner mo If Under 1 Year GENERA 5. Social Security Number

0.66-36-45

Usual Rasidance of Decedant If Undar 24 Hrs. 8. Data of Birth piace (State or Foreign **Funeral** 1□M 20 F Months Days Hours Min Yrs. Director the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director land 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? d Funeral 12. Wes Decedent Ever In U,S. Armed Forces?

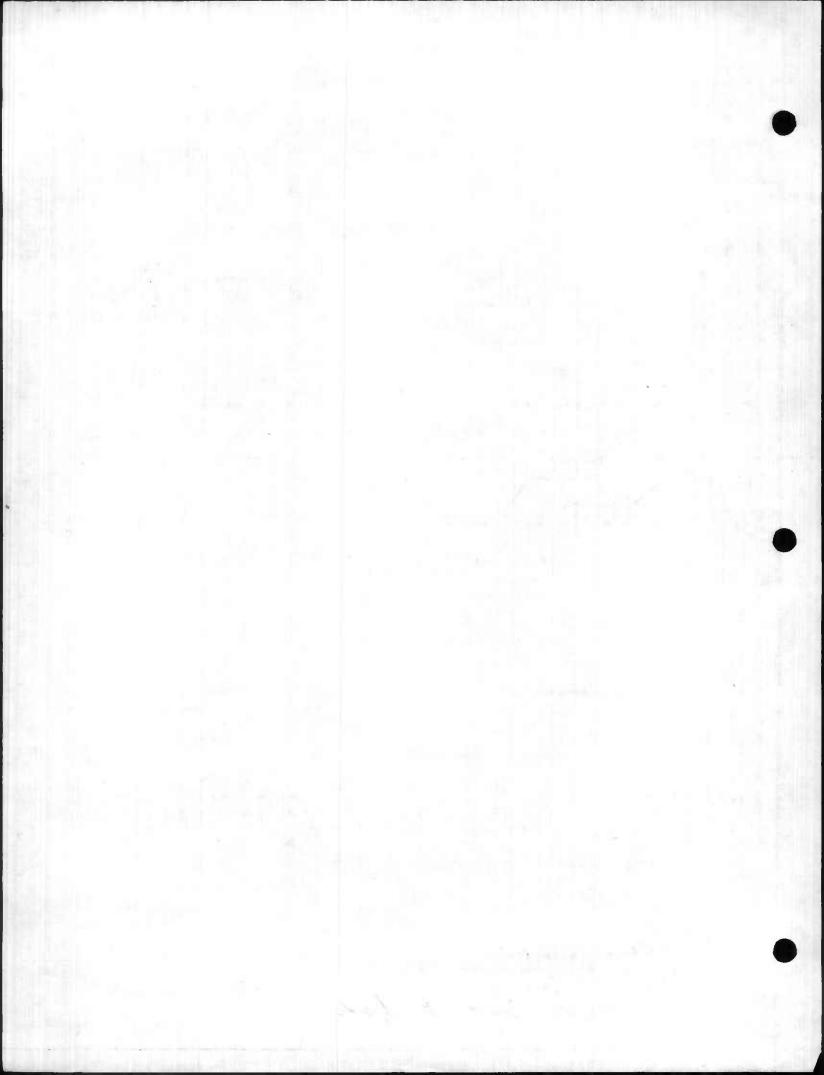
1 Yes 2 No If Yas, Give Yeer or Detas: Wes Decedent of Hispenic Origin? (Specify Yas or No If Yas, apecify Cuban, Mexican, Puarto Rican, etc.) 11. Maritel Status 14 Race American Indian Black, Whita, atc. should be filed within 72 hours after 2 Married 1 Never Married 1□ Yas 2⊠ No Specify: p 3 Widowed 4 Divorced 0910 Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industr permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other treumatic event, the Health DRE. Elamantery/Secondary (0-12) College (1-4or 5+) BROWN 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Symama) Be 0 Brother 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip,Coda), 2.7 2 Box 20b. Place of Disposition (Name of comptary, cramatory or other place) 20a. Mathod of Disposition City or Town, Stata 1 Burial 2 Crametion 3 Ramoval from State 4 □ Donetion 5 □ Othar (Specify) 21. Signature of Funeral Service License 22. Name end Address of Family Jose 0 222 Pe.(1) Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** /Medical Immediate Ceusa (Final disaasa or condition rasulting in death) Examiner Due to (or es e consequence of): Stage Examiner physician and the burial-transit certificate be executed Sequentially list conditions, if any, leading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initieted avents resulting in daeth) Lest Dua to (or as a consequence of) Pulmonary Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 88 950 signed by the a Part It. Other stgniftcant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 28 No 1 Yes þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performad? peed completion of cause of death? After this certificate has 2 C No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA funeral 28a. Deta of tnjury (Month, Day Year) 27. Manper of Death 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? Netural 5 Panding Invastigation 2 🗆 No 1 ☐ Yas Ne Hospital or Attendi n 24 hours after death. Ne Funeral Director: A death. 2 Accident 3 ☐ Sulcida 6 Could not be datarmined 28f. Location (Streat and Number or Rural Route Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, atraat, factory, offica building, atc. (Spacify) filled in by 4 Homicide 29a. Certifier (Check only one) 🔀 Certifying Phyelcian: To tha best of my knowledga, death occurred at the tima, date and place, and dua to tha causa(s) and mannar as statad. Medical completely 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) and mannar stated. Within 2 To the 29b. Signatura and titla of certifie 29c. Licansa number 29d. Data signed (Month, Day, Year) 126 2 30. Nama and addrass of person who completed ceusa of daeth (Item 23e) (Type, Print) Go MARyland ELISA (7) 31. Data filed (Month, Day, Year) 32. Registrer's Signatura State Registrar **DHMH 16 Rev 6/95**



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State of Maryland / Department of Health and Mental Hygiene	0.0
Cartificate of Death	22

ASP TYRONE	R.	BLACKWELL	State	of Marylar		artment o			and N	Mental Hy	giene Reg. No.	99	23955
Physician	_	1. Decedent's Name (First, Mid	die, Last)							2. Date of De Month	eath Day	Year	3. Time of Death
Physiciar /Medica	ıł .	Tyrone Blackwe								JULY	25	1999	2310
Examine	r	la Facility Name (If not instituti								ocation of Deat	h 4c. Cou	inty of De	ath
		1500 BLK 5. Social Security Number	EDMONDSON 6. Sex	7. Age (In yrs.	last hirthday	If Under 1		BALTII If Under			th	0.8	idhalaan /Stata as Fassi-
Funeral Director		215-94-7067	1 XM 2 □ F		Yrs.		Days	Hours	Min.	8. Date of Bi	Y 978	Man	irthplace (State or Foreig Sountry) Cy Land
	-	Usual Residence of Decedent											
how		10a. State 10b. Coun	ty	10c. Ci	ly, Town or L	ocation							10d. Inside City Limits 1 XYes 2 No
death with the Maryland		Maryland		Ba	ltimor								
a di di	בַּ	10e. Street and Number				10f. Zip Co	ode				10g. Citizen	of What C	Country?
# 23 # 23	a e	406 S. Pulaski 11. Marital Status		cedent Ever in U	S 12		223	enanic Oric	nin? (Sn	acify Van or N	U.S.A.	Race - Am	nerican Indian,
_ 5 25 3	by Funeral Director	1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed	Forces? 3 2 TNo Give		If Yes, specify	-	Specify:	, Puerto	ecify Yes or No Rican, etc.)		Black, Who	ite, etc.
72 hours	9	15. Decede	ont'a Education		16a. Dece	dent's Usual C	Occupa	tion			16b. Kind o	f Busines	s/Industry
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d 212 flied with Hygiene. ther ther ent, the I	5	9			Une	mployed	1				None		
yland yland Mental H mred off	מ	17. Father's Name (First, Middle								e (First, Middle			
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Mar d 2 sh d 2 sh ith end 7 le m traum	1				1					al Route Numb	0.70		
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Baitimo pemit. Page Department Important: If eny Injury or		21. Signature of Funeral Service	C.		41	511 Par	k I	leight	ts A	ve., Ba	itimor	ones ce, M	aryland 2121
deeth certificate be executed e ettending physician and of for use as the burial-fransit		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (d	or as a conse	quence of):	3.7	101		Dung	3		
P.O. BOX 68 set the death certifical day the ettending physical for use as the Dhysic length.	Dawa.	resulting in death) Last	L a										
de ett	2	Part II. Other significant condit	ions contributing to	death but not res	ulting in the u	inderlying caus	se give	on in Part I.		23b. Did	tobacco use	contribu	te to the cause of death
the the deep detached for	ŽIL.										Yes 2MIN		Probably 4 Unknow
Cords, requires to the should be the sign.	Sieted Dy									24a. Was	an autopsy ormed?	240	Were autopsy findings available prior to completion of cause of death?
He se se se se se se se se se se se se se	5									ोड	Yes 2□N	0	1 XYes 2□ No
r Vital Re- ysicien: The lav sentificate hes director, page 2		25. Was case referred to medic	al					26. Place	of Deat	h (Check only			
		examiner? ↑ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DOA	Othe	er: 4 🗆 Nu	rsing Ho	ome 5 Res	Idence	Other (Sp	pecify) SCFNE
There there are a rect		27. Manner of Death 1 Natural 5 Pend	ing 28a. Dat	e of Injury onth, Day Year)	28b. Time of Injury	of 28c	Injun Won	at c?		28d. Describe	1 1 1	curred	
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Division of the funer death. The after death. The funer death. The funer death. The funer death. The funer death.		4 Homicide deter	miner 206. Pla	ce of Injury - At h Iding, etc. <i>(Specil</i>	6/1	reet, factory, o	ffice			City or To			Rural Route Number, ock Edmonson
Division of whether the Manual Manual Manual Manual Director: After this completely filled in by the funeral director. After this completely filled in by the funeral director.			ing Physician: To the	basis of examina	wledge, deat	h occurred at t					cause(s) and	manner.	as stated.
of the office of	E	29b. Signature and title of certifi		inner stated.		29c. L	icense	number			29d. Date si	gned (Mo	nth, Day, Year)
- 3 - 3			Muden				C.N	1.E			JULY 2		
		Dennis J	Chute,	MD		111 F		Str	eet,	Baltin	more, N	Maryl	and 21201
State Registrar		31. Date filed (Month, Day, Yea. JUL 3 0 1		Registrar's Signa	G.	Spark							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23956 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Tima of Death Mogth Day 23 **Physician** 12:05 pm saummer /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** BALTMORP, CITY
H Under 24 Hrs.
Hours Min.
Nov. 21, 1927 JOHNS 5 HOS PITAL 7. Age (In yrs. last birthday) HOPKINS 5. Social Security Number If Under 1 Ye Birthplace (State or Foreign Country) **Funeral** Months Days 100 M 2□ F Yrs. 216-24-9398 71 Baltimore City, MD. Usual Residence of Decedent 10a. Steta 10h. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Maryland Baltimore Kingsville 10e. Street and Number 10f Zip Code 10c. Citizen of What Country? 7217 New Out Road 21087 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if ten 27 la merked other there. any injury or other trausments. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Black. Whita, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. 13 yrs. Principal Baltimore County Public Sch. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Francis Baummer Mark Catherine Parr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Baummer (Wife) 7217 New Cut Road Kingsville.Md.21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State Highview Memorial Gardens 7/28/99 Fallston,MD.21047 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility
E.F.Lassahn Funeral Home 21. Signature of Funaral Service Libens 11750 Belair Rd. Kingsville, Maryland 21087 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediata Causa (Final disaasa or conditior resulting in death) e MOUTS Examiner ibnilation Daar Due to (or as a consequence of)

Physician /Medical Examiner

and

3

certificate

this

After

To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fund

funeral director.

signed I

the th

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

or Attanding Physician:

Director

Show

mast be notified at

or Name

death with the Maryland

Physician/Medical Be Completed by Medical Certification: To

Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last

umman embolism Due to (or as a consequence of) sepsi

6 days 23b. Did lobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 Yea 2 No

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

elodysplastic syndrome

24a. Was an autopsy performed?

1 X Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

25. Was case referred to medical examiner? 1 Yes 2 No

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b Time of

26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural
2 Accident 3 Suicide

4 Homicide

5 Pending invastigation 6 ☐ Could not be

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

29b. Signatura and titla of certifier

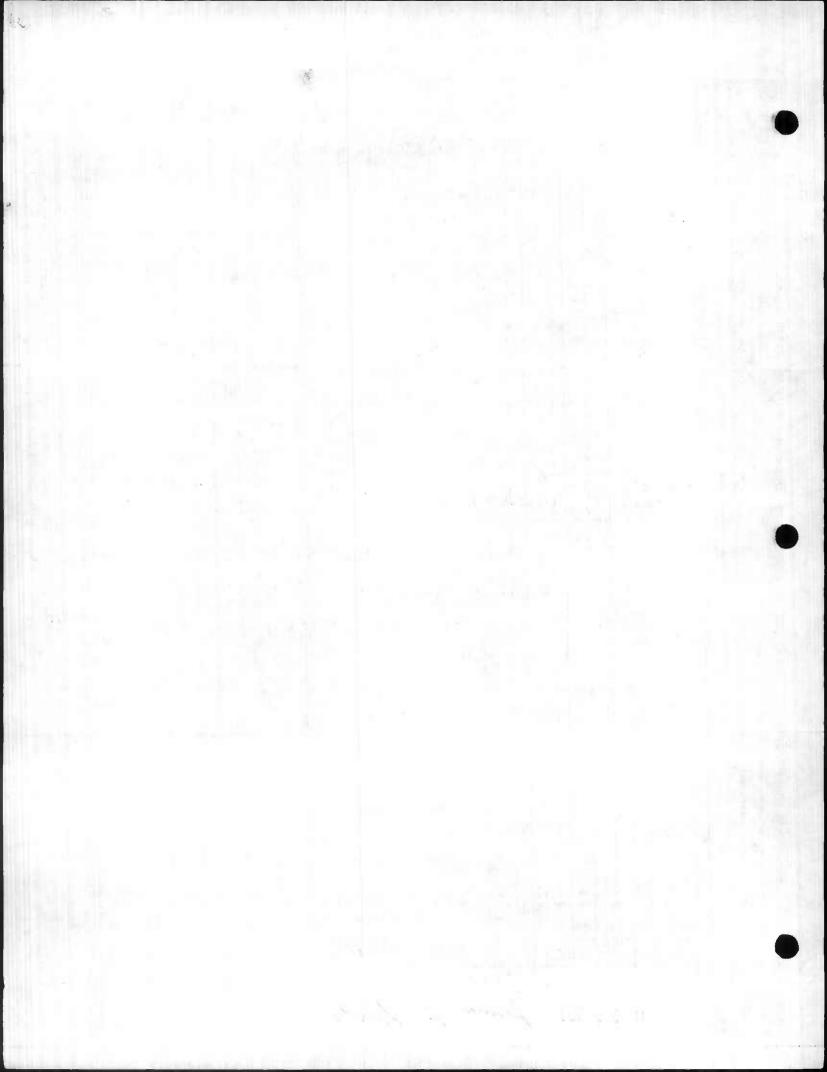
Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

Hennes Rd Baltimore, MD 400 31. Dete filed (Month, Day, Year)

State Registrar

JUL 3 0 1999

Registrar's Signature 32



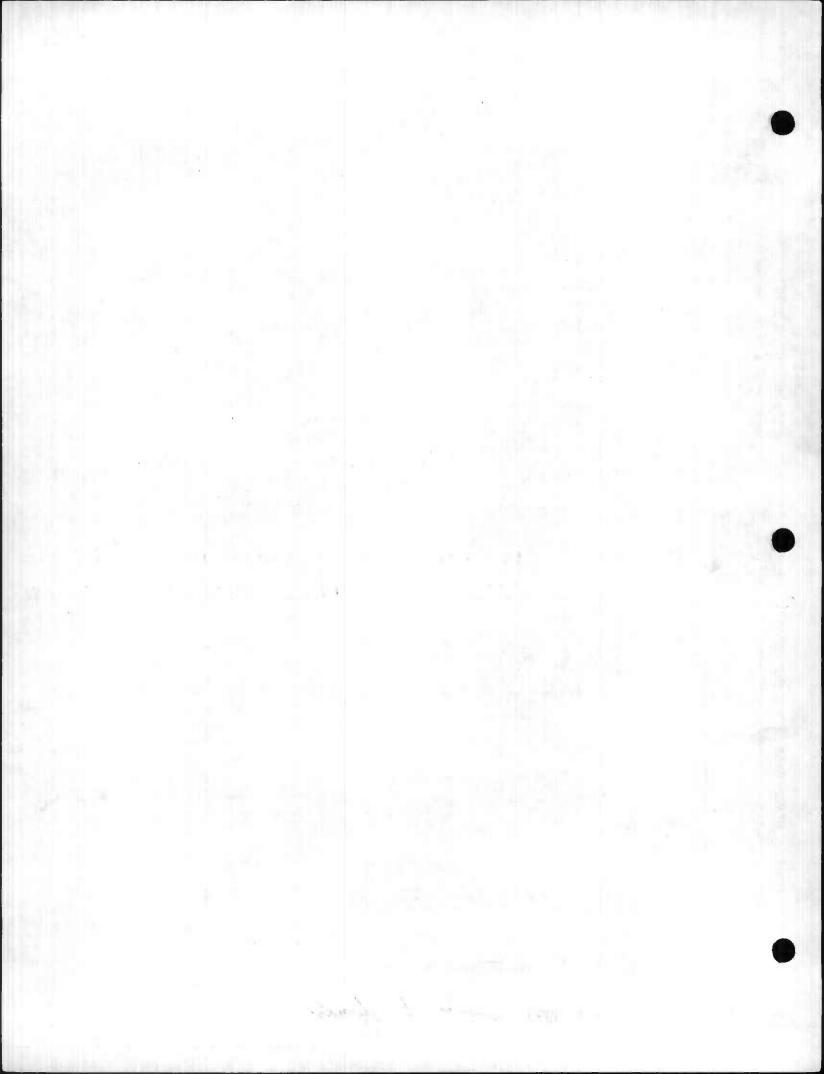
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State of Maryland / Department of Health and Mental Hygiene 99 23957

			Ce	ertificate c	f Death		Reg. N	lo.		
sician edical	Decedent's Name (First, Middle, Last) MADELINE M.	BARWIC	:K			Mont		Dey Yea 1999		of Death O P.M
ner	4a Facility Name (If not institution, give str MILLENNIUM HEALTH &		TION C	ENTER		own, or Location of BURNIE		Ic. County of De		
	5. Sociel Security Number 6. Sex 1 h	7. Age (In your 80	rs. last birthday Yrs.) If Under 1 Ye Months Day		Min. (Moni	h, Day, Yea	9. 8 1918 M	Sirthplace (State Country) ARYLAND	
lor	10e. Stete 10b. County MARYLAND ANNE ARUN		City, Town or L	ocation SEVERN						City Limits
i Director	10e. Street and Number			10f. Zip Cod				Citizen of What		
Completed by Funeral	8524 BRAUNS AVE. 11. Merital Stetus 1 Never Merried 2 Merried 3. Widowed 4 Divorced	Wes Decedent Ever in Armed Forces? I Yes 257No If Yes, Give Year or Dates:	U,S. 13.	2114 Wes Decedent of If Yes, specify C	f Hispanic Ori uban, Mexicar	igin? (Specify Yes n, Puerto Rican, etc	or No-	ITED STA 14. Raca - An Bleck, Wi Specify: WI	merican Indian hita, atc.	
mpleted	15. Decedent's Educa (Specify only highest grade of Elementery/Secondary (0-12)	tion ompleted) College (1-4or 5+)	(Give	edent's Usuel Oc e kind of work do DO NOT use ret I CLERK	cupation ne during mos ired)	at of working		Kind of Busines	ss/Industry	
Be	8 17. Father's Nama (First, Middle, Last) JAMES WILLIAM THO	MAS DEVAN				er's Neme (First, M RY ELLA C	liddle, Maide			
To	19a. Informant's Name/Relationship (Type PEARL SCHNEIDER/DAU		1.	ling Address (Stra		er or Rural Route I				1-1
	20a. Method of Disposition 1	noval from State	cemetery, cre	osition (Name of ematory or other I		JULY 31		Location - City of		
	21. Signature of Funeral Service Dicensee	- 1	K		UDDICK	FUNERAL S.E., GI	HOME,	P.A.		1
Medical Examiner	Immediate Cause (Finet disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	Due to	(or as a conse	oquence of):	7111	ug co) N		200	yns
Physician/	Part II. Other significant conditions contril	buting to death but not r	esulting in the	underlying cause	given in Pert I	I. 23b	. Did tobac	co use contribu	ute to the caus	se of death?
by Phy							1 Vea	2 No 3	Probably 4	Unknown
Completed by						248.	Wes an au performed?		b. Were autop available pri completion of death?	or to
Be Cor	25. Was case referred to medical				26 Place	e of Death (Check		2XI No	1 Yes	2□ No
To B	examiner? 1 Yes 2 No	pital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA	0.1	ursing Homa 5		6 □Other (S _i	pecify)	
Certification:	2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time Injury	\		No 28d. Des	cribe how in	jury occurred		
Certifi	3 Sulcide 8 Could not be 4 Homicide determined	28e. Plece of Injury - Al building, etc. (Spe	home, ferm, s	treet, fectory, offi	> 0	28f. Loca City	tion (Street or Town, St	end Number or ete)	Rural Route N	lumber,
edical	29e. Certifier (Check only one) 1 ☐ Certifying Physici 2 ☐ Medical Examiner	en: To the best of my k : On the basis of exami and manner steted.	nowledge, dee netion end/or i	th occurred at the nvestigation, in m	time, date an y opinion, dee	nd place, end due t eth occurred at the	o the cause time, date a	(s) and manner and place, and d	as stated. Jue to the caus	se(s)
×	29b. Signature and title of certifier				2) &	38		Date signed (Mo		1)
		M.D., 518	S. CAM		RD., L	INTHICUM	, MAR	YLAND 2	1090	
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	neture /			_				

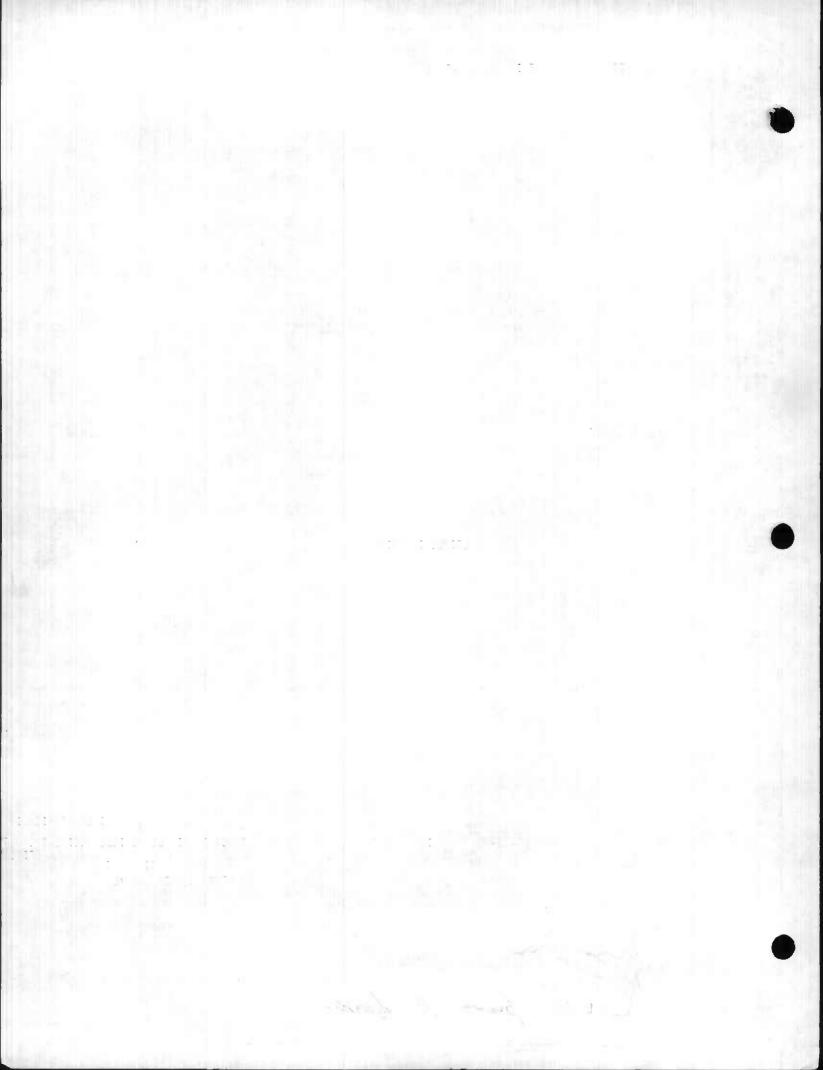
DHMH 16 Rev 6/95

Registrar



JNK 9 asp	99-163			State of M	larylan	d / Dega	utment	of	lealth and l	Mental Hy	gieneg 9		358
ROBE	Physician		ER AMEND ITEMS: #23 PA 1. Decedent's Name (First, Middle, Las ROBERT E. BAKER		28A-F [MEO COI	incate	01 1	Dealli	2. Date of De Month JULY	Reg. No. ath Day 199	Year	Tima of Death
	/Medical Examiner		la Facility Name (If not institution, give)			1	1b. City, Town, or I	Location of Death		of Death	220
	Funeral Director		i. Social Security Number 6. Se	RD. X M 2□ F 26		last birthday) Yrs.	If Under 1 Months	Year Days	ABINGDO If Under 24 Hrs. Hours Min.		h		(State or Foreign
yland	8 w	-	Oa. State 10b. County		10c. City	y, Town or Lo	cation					10d. ir	nside City Limits
e Mar	ctor		MARYLAND HARFORD		ABI	ERDEEN							☐ Yes 2X No
vith th	or 28ef a	1	Oe. Street and Number	0.4.0			10f. Zip 0				10g. Citizen of \		
thee	mark mark	5 .	623 CARSINS RUN R	UAD 12. Wes Decedent	Ever in 11	C 13 V		.001		nacify Vas or No	U.S.A.	e - American In	dian
1215-0020 within 72 hours after death with the Maryland	il, or tems 23s or 28s-1 show Lastings must be notified at by Funeral Director		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Giva Yeer or Detes:	?		Yes, specif		lispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Specify	ck, White, etc.	
5-06			15. Decedent's Edu			16a. Deced	lent's Usual	Occup	ation	dina	16b. Kind of B	usiness/Industry	
64 5	Dan Dan O		(Specify only highest grade Elementary/Secondary (0-12) 12TH GRADE	College (1-4or	5+)	MECHA	OO NOT use	retired	during most of wor 1)	King	INDUSTE	RIAL EQU	JIPMENT
pue s	T 45 E	1	7. Father's Name (First, Middle, Last)						18. Mother's Nan		Maiden Suman	ne)	
Maryiand	h and Menta		DONALD BAKER, SR. 19a. Informant's Name/Relationship (T)	ima Printi		10h Mailin	n Address ((Stront	FRAN S		e City or Tou-	State Tin Cod	(a)
Ma Ma	27 la n r traur	1	DONALD BAKER, SR.)		BRD. S			TIMORE,		206	7/
s a	of Health I fem 27 r other tr	2	20a. Method of Disposition		20b. P	lace of Disposemetery, crem	sition (Name	e of	1	Date		City or Town, S	State
Baltimore,		-	1 ☐ Burial 2 ☒ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens)		EEN_MOU	JNT CR	EMA	1	7/28/99	BALTIM	ORE, MA	RYLAND
Example	ysician Medical aminer Examiner		immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, and any, leading to immediate sause. Enter Underlying	a	Due to (or	E INJURI	uenca of):					Ons	et and Death
Box 68760, death certificate be ex	anding physicia use as the bur an/Medical	. 1 2	Cause (Diagnes or Initial	d	Due to (or	es a consequ	uence of):						
D. B	the attend for hed for	F	Part II. Other algnificant conditions co	ntributing to death b	out not resu	ulting in the un	nderlying car	use giv	ren in Part t.	23b. Did	tobacco use co	ntribute to the	cause of death?
S, P.O	igned by the detact									10	Yas 2□ No	3 Probably	48)Unknown
Records, P	should should	-									an autopsy med?	availabl	utopsy findings le prior to tion of cause 1?
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Vitai	Bector Be	2	25. Was case referred to medical examiner?	Hassite!				Out		ath (Check only o	nne)		
O E	T die	-	ty Yes 2 No 7. Manner of Death 1 Netural 5 Pending	Hospital: 1 ☐ Inpati 26a. Dete of Inju (Month, Da	ury	ER/Outpatien 28b. Tima of Injury		Oth Ic. Injur Wor	4 LI Nursing H	forme 5 Thesis			OF PICK_S
	is after death. al Director: After to the funeral to the funeral Certification:		Accident investigation 3 Suicide 6 Could not be determined	7-25-99 28e. Place of Inbuilding, ef	jury - At ho tc. (Specify	1:30 me, ferm, stre	M eet, factory.		Yes 2∭No	28f. Location (: City or Tox	SINGLE V Street and Numbers, State) 110	per or Rural Roll 3 ABINGD	CCIDENT CAUG Ule Number, TR ON ROAD
• Hospital	Funer Funer etely fil	1	29a. Certifier (Check only one) 1 Certifying Phy Medicat Exami	atcian: To the best	f examinat	wledge, death ion end/or inv	occurred et restigation, i	t the tin	ne, date and place pinion, death occu	, and due to the	cause(s) and m	anner as stated	cause(s)
Toth	To the comple		29b. Signature and title of cedifier	p				Licens C.N	e number 1.E		29d. Dete signe	d (Month, Day, 26, 1999	Year)
			0. Name and addrage of person who co	}				Penr	Street,	Baltim	ore, Mai	ryland 2	21201
	State Registrar	3	JUL 3 0 1999	32. Registr	rar's Signal	B.	Sport	h)					

Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDEDITITEM#10e PER FH G773 7/30/99 AH 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** July 28, 1999 Gregory E. Bushman 5:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4209 Garland Avenue Perry Hall Baltimore HUnder 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) April 11, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days **₩** 2□ F 216-56-8681 Yes Director 33 1966 Maryland Usuel Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 ☐ Yes 2 ☑ No Director Maryland Baltimore 284-11 Phoenix 10e. Street and Number 4209 GARLAND AVE 10f. Zip Code 10g. Citizen of What Country? 6 Box 285 Norma 23a 21131 United States P.O. Funeral 14. Race - American Indian, Black, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus permit. Peges 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental hygiene. Important: If Itsm 27 is marked other than "natural", or flee any injury or other traumatic event, the second of the summer. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Detes: Baitimore, Maryiand 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry T. Bushman Forest Elementary/Secondery (0-12) College (1-4or 5+) 12 Products Company Sales 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0 Thomas F. Bushman, Sr. Pamela F. Bitz 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pamela Hoffman 106 White Oak Road Rehobeth Beach, Delaware 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 7/31 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Woodlawn, Maryland 22. Neme and Address of Facility 21. Signature of Funeral Service Licensee Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): The law requires that the death certificate be execu P.O. Box 68760. the Due to (or es a consequence of) USB AS Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 105 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 bale 1 □ Yes 2 □ No certificate of Vitai Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Discribe how injury occurred 28b. Time of 28c. Injury at Work? Affer Division 1 Delivetural 2 Accident 5 Pending investigation within 24 hours after deeth. To the Funeral Director: At 1 Tes 2 No filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier completely To the 29b. Signeture end ittle of certified 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST BAUTIME

DHMH 16 Ray 6/95

State

Registrar

ELANO

JUL 3 0 1999

31. Date filed (Month, Day, Year)

32, Registrar's Signature

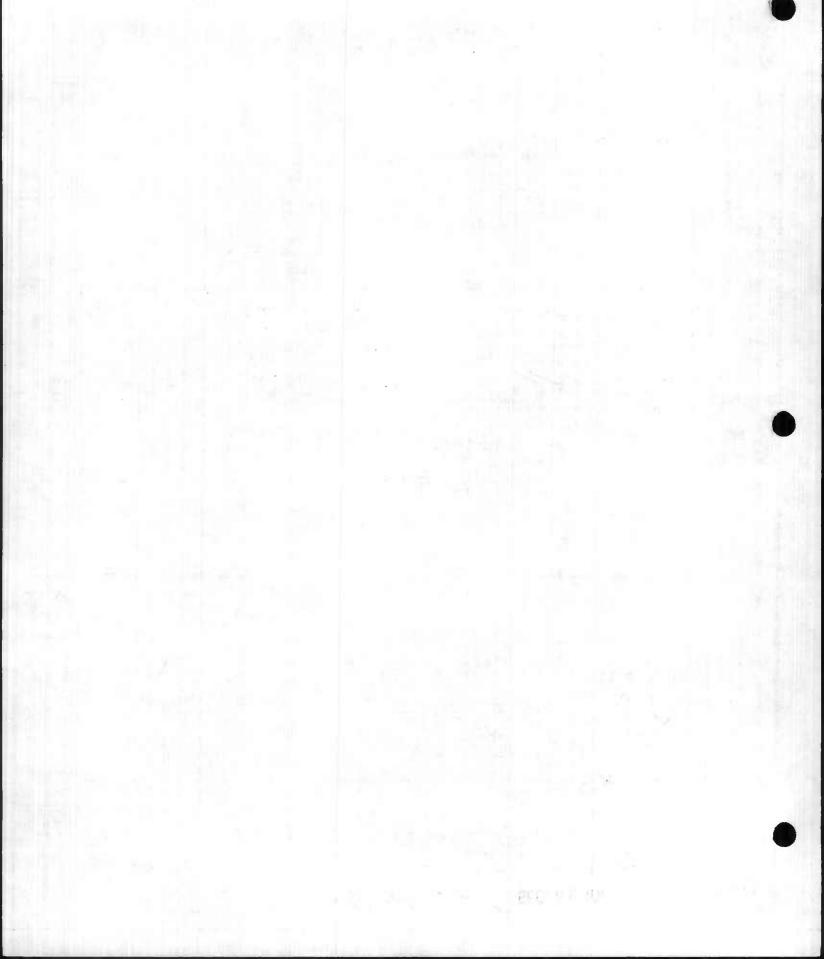
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State of Maryland / Department of Health and Mental Hygiene

				Certificate of	of Death	Reg	No	20000
	1. Decedent's Name (First, Middle,	Last)				2 Date of Death		3. Tima of Death
Physician /Medical	JOSEPHINE ANTOI	NETTE BACCA	ALA			July 29	Day 1999 Ye	4:10 p.n
Examiner	4a Facility Name (If not Institution,	give street end number)	-		4b. City, Town, or I	Location of Death	4c. County of D	
	Sunshine Acres	Assisted L	ivina		White Ho	ill	Baltime	ore.
uneral			e (In yrs. last b	rithday) If Under 1 You Yrs. Months De	eer If Under 24 Hrs. Bys Hours Min.	8. Date of Birth (Month, Day, Young)	9. 1006 H	Birthplace (State or Forei
irector	Usuei Residence of Decedent					June 0,	1908 M	aryland
M 16	10a. State 10b. County		10c. City, Tov	n or Location				10d. Inside City Limit
10	MD. Harko	rd	Church	wille				1 ☐ Yes 2 ◯ N
ired	10e. Street and Number		1	10f. Zip Coo	le	10g	Citizen of What	Country?
a D	2824 College V	iew Drive		2102	2.8	u	.S.A.	
, or theme 23s or 28s-fahow danible must be notified at y Funeral Director	11. Merital Stetus	12. Was Decedent Armed Forces?		13. Was Decedent It Yes, specify (of Hispanic Origin? (S Juban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		merican Indian, /hite, etc.
200 10	1 □ Never Married 2 □ Marrie 3 Ø Widowed 4 □ Divorced	If Yes 2⊠ If Yas, Give Year or Dates:	No	1 □ Yes 2 🖔	No Specify:		Specify:	White
P P	15. Decedent's	Education	168	. Decedent's Usuel Oc	ccupation	16	b. Kind of Busine	
	(Specify only highest Elementary/Secondery (0-12)	grade completed) College (1-4or :	5+)	(Give kind of work do life. DO NOT use re	one during most of wor tired)	king		
marked other than imarke event, the Market To Be Comp	Unknown	05.1050 (1.10.1		Seamstress			Clothing	g Industry
46 6	17. Father's Name (First, Middle, L.					ne (First, Middle, Ma		
arked out atic evan	Joseph Marsonet				Stella.	Unknown)	
9 5	19a. Informant's Name/Relationshi			b. Meiling Address (Str				
22	Gina Kilby (Gra	and daughte		2824 Colleg				
r othe	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	3 □Removal from State	20b. Place o	of Disposition (Name or ery, crematory or other	place)	Date 20	c. Location - City	or Town, Stete
ury	4 □ Donation 5 □ Other (Spe		Bel A	ir Memoria	l Gardens!	8/2/99	Bel Air,	Maryland
important: If its any injury or of once.	21. Signature of Funeral Service Li	censee		22. Name end Ad	Idress of Fecility	Hama at P	.2 17.	Tue
5 2 9	1/1/1/			610 W.	k Funeral MacPhail F	Road. Bel	Air. MI	21014
	23a. Pell 1. Enter the disease, or c shock, or heart teilure. List of	complications that caused	the death. Do					Approximate Interval Between
sician	Shoot, of Hook tollars. Elst of							Onset end Deeth
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aminer	resulting in death)	a	P					YEARS
i i			1	type ten	SION			years
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	Sequentietly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
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attendin for use clan/N								
44		a annially office an elegate by						
the all	Pert tt. Other significant condition	Contributing to death b	ot not resulting	in the underlying cause	given in Part I.	23b. Dtd tobs	cco una contrib	uta to the cause of deat
d by the letached	Pert II. Other significant condition	s contributing to death b	ot not resulting	in the underlying cause	given in Part I.			puta to the cause of deat
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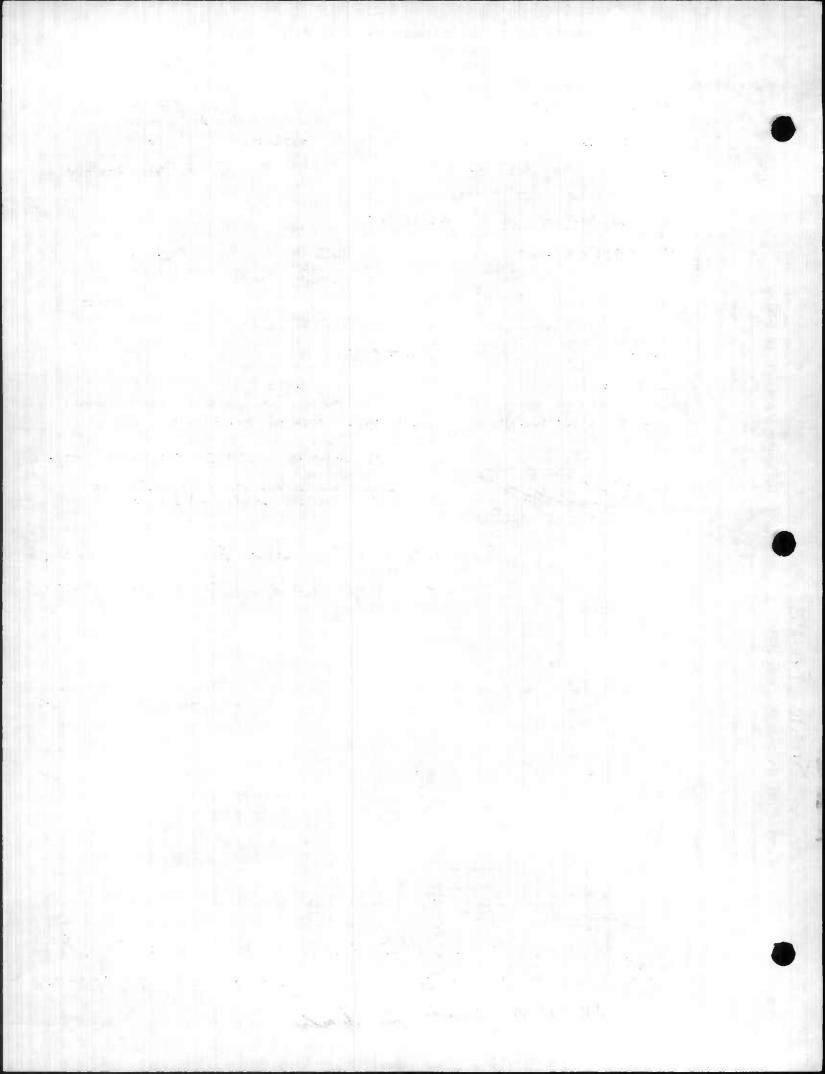
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State of Maryland / Department of Health and Mental Hygiene 9 9 2396

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	1. Decedent's Neme (First, Middle, La	ast)					2. Dete of Month	Death Day	Year	3. Time of Dear
Physician /Medical	SHEILA MARY BROO	KS					101	1 27,	1999	8:380
Examiner	4a Facility Neme (If not institution, gh	ve street end number)				4b. City, Tow	n, or Location of D	ath 4c. Cou	unty of Deeth	
	Union Memorial H	ospital				Balti	more	N/A	4	
Funeral Director		Sex 7. Age 1□M 2√F 68	e (In yrs. last i		If Under 1 Y Months D	ear If Under 2 eys Hours		Day, Year)	9. Birth	piece (State or For ntry) cland
100	Usuei Residence of Decedent		40. Oh. T.							
ahow dan	10e. Stete 10b. County		10c. City, To	wn or Loca	ation					10d. Inside City Lin 1 ☐ Yes 2 🔯
eto octo	Maryland Harfor	d	Fore	st Hi	1					41
23e or 28e-fa ant be notified al Director	10e. Street end Number 1621-E Louanne C	ourt			10f. Zip Co 210	^{de} 050		Engla	of Whet Coul and	ntry?
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by Ja	1 ☐ Never Merried 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N if Yes, Give Year or Dates:	lo		Yes 2√X		1 40110 1110411, 010.,		noihu	ite
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T is marked other traumatic event,	17. Father's Name (First, Middle, Last	U)				18. Mother	s Neme (First, Mid	dle, Maiden Sur	name)	
To E	Albert Dutson					Anni	e Fawcett			
E S	19e. informent's Neme/Relationship ((Type, Print)	1	9b. Mailing	Address (S	treet and Number	or Rurel Route Nu	mber, City or To	wn, State, Zij	Code)
	Wendy Hallgarth	(Daughter)		256 W	akely	Terrace	, Bel Ai	r, MD.	21014	
mant of neers ant: if item 23 ury or other i	20e. Method of Disposition		20b. Plece	of Disposit	tion (Name of	of rolece)	Date	20c. Locati	on - City or To	own, Stete
7 C H I	1 ☐ Buriel 2 ☒ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special					matory	7/29/9	9 Balt	imore.	Marylan
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Department of Important: If any Injury or DOCE.	1///	///		Sc	himune	k Funer	al Home o			ic.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Name (First, Middla, Last) 0.S.P. 2. Data of Death Sister **Physician** allista :05 unningham 46. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deat Sisters 0 f 2 HCU Baltimore rovidence aton sulle If Under 1 If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) Days 1□M 20 F 20-56-055 Yrs. Usual Rasidence of Dacedeni 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 13a Himore atonsville 10e. Street and Number 10g. Citizan of What Country? 10f. Zio Code Koad 1/0 21227-3899 Funeral 12. Wes Decedant Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Merital Status 1 Yes 2 No If Yas, Giva Year or Detes: t Never Merried 2 ☐ Married Black 1 ☐ Yes 20 No by Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry School Elementary/Secondary (0-12) College (1-4or 5+) NA ex 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be 0 Lunningham aru Lones 19a. Informant's Name/Raiationship (Type, Print) U.SP. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Celestina Johnson 1 trmore 21227-3899 Koad 20a. Method of Disposition 20b. Place of Disposition (Name of Data 20c. Location - City or Town, Slele 1 Buriai 2 Cremetion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) enetery 21. Sone rerof Funeral Service License 22. Nama and Arrass of Fro 2/2/5 300 20 140 Mg 23a. Parl 1. Enter the dheasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart half re. List only one cause on each line. Approximata Intervel Batween Onsat and Death tmmediata Causa (Final disaasa or condition rasulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence ot) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yea 2 Prio 3 Probably 4 Unknown Be Completed by 24b. Wera autopsy tindings available prior to 24a. Was an autopsy parformed? completion of cause of death? 1 Yas 2 No 1 Yas 200 No 25. Was casa ratarred to medical 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Amesidence 8 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 8 Could not be 28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledga, death occurred at tha time, data and piace, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mennar stated. 29a. Certifier

The law requires that the death certificate be executed P.O. Box 68760, Records, of Vital To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica Division

/Medical

Examiner

Funeral

Director

ahow

rai", or items 23a or 28a-f ahov Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after man of Heelin and Mental Hygiens.

mri: If Itam 27 is marked other than "natural", or he ury or other traumatic event, pr. stages.

permit. Pages 1 and 2 Department of Heelth a Important: If Itam 27 is any injury or other tracents.

Physician

/Medical **Examiner**

bunal-transi

the th

is certificate has been signed by the attending p director, page 2 should be detached for use as

this certificate

completely filled in by the funeral

Baltimore, Maryland 21215-0020

State Registrar

edical Certification: To

31. Data tiled (Month, Day, Year), **DHMH 16 Rev 6/95**

29b. Signature and fitta ot certifiar

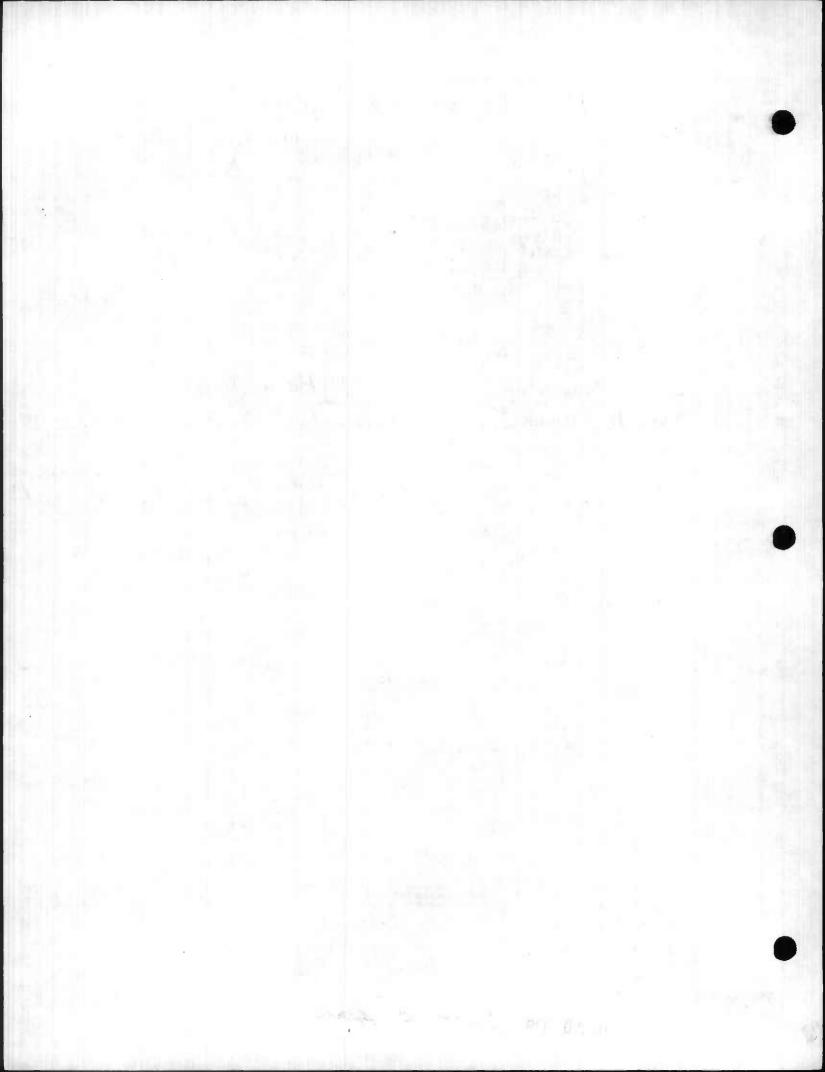
BASKARAN

30 Mama and addrass of person who completed cause of death (Item 23e) (Typa, Print) 32. Registrar's Signatura

29c. License number

29d. Deta signed (Month, Day, Year)

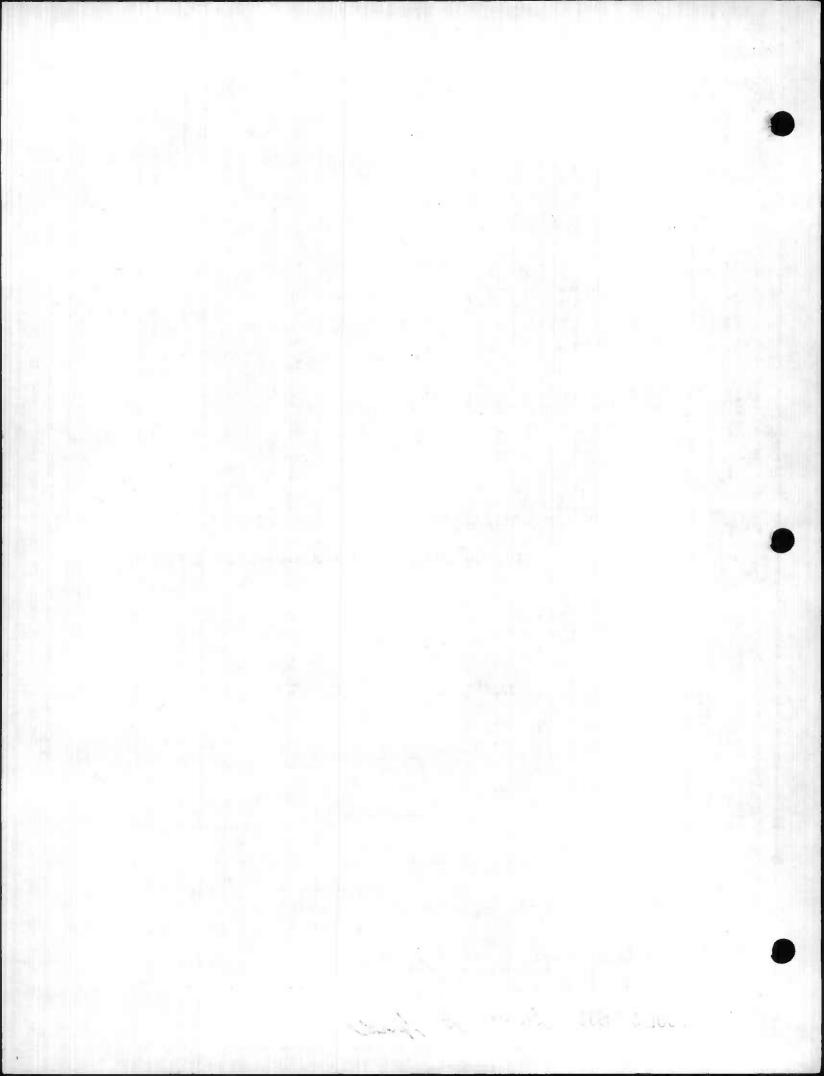
Ave. Bultimore. MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydione

			State of Marylai	Certifica				Reg. No.	239	963
Physic /Medi		1. Decedent's Name (First, Middle, La	Lee Co	field			2. Date of De Month JULY	Day	Year (Time of Death)833 AM
Exami		4a Fecility Name (If not institution, giv UNIVERSITY OF MA)		CENTER		4b. City, Town, or BALTIMOF		4c. County	of Death	
Funeral Director		017 17 19071	ex 7. Age (In yrs.	dast birthday) If Und Month	ler 1 Year s Days	If Under 24 Hrs Hours Min.		15,1959	9 Birthplace (Calintry)	(State or Foreign
after death with the Maryland or Neme 23s or 28s-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10 Tyland	A 10c. Ci	1	mo	re		•		Yea 2 No
th with the	al Dire	10e. Street and Number 1535 N	Ellamon	+ St 101.	Zip Code	1216		10g. Citizen of V	What Country?	
Surs Fig.	by Funeral	1. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	II Yea, sp	edent of I becify Cub 2 No	Hispanic Origin? (S an, Mexicen, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify	e - American Inc ck, White, etc.	dian,
C F 2	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's Us (Give kind of s life. DO NOT	ual Occup vork done use retire	pation during most of wo	rking	16b. Kind of B	usiness/Industry	
filed within Hyglene. ther than		Elementary/Secondary (0-12)	College (1-4or 5+)	Surgico	1	echni	can	Ho	Spita	u
d 2 should be filed within the and Mental Hyglene. 7 is marked other than traumatic event, the Mental traumatic event, the Mental traumatic event.	To Be	17. Father's Name (First, Middle, Last) Herbert 19a. Informant's Name/Relationship (- Cotiel	19b. Mailing Addre	ess (Street	Gar	me (First, Middle, Netto	a L	ewis	>
nd 2 alth ar trav		Mrs. Garnet	ta Cofiela	1535	N.	Ellan	nont :	St. Bo	uto. M	d.21211
80-7	y	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	Place of Disposition (A cemetery) crematory of		oo)	7/31/99	20c. Location	City or Town, S	1A
permit. Pages 1 a Department of Her Important: If Nem any Injury or othe pages.		21. Signature of Funeral Service Liber		22. Name JOS 1 3 7 3	and Addre	ass of Facility	uss F	uner	al Ho	me 1316
		23a. Part1. Inter the disease, or comshock, or heart fallure. List only	plications that caused the deal one cause on each line.	th. Do not enter the m	ode of dyi	ng, such as cardia	c or respiratory a	rrest,	Appi Inter Ons	roximate val Between et and Death
Physician /Medical Examiner	ner	Immediata Cause (Final disease or condition resulting in death)	a. Atherose Due to (Jeretic or as a consequence of		diovasc	ular l	Diseas	e	
axecuted n and al-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequence o	f):					
entificate be executed ling physician and se as the bunal-transit	edical	Cause (Disease or Injury that initiated events resulting in death) Last	C. Due to (c	or as a consequence of	n):					
death certifi e attending od for use as	Physician/M	Part II. Other significant conditions o	ontributing to death but not res	sulting in the underlying	cauae oi	ven in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death?
es that the de igned by the a be detached i							10	Yea 2 No	3 Probably	4 Unknown
law requires that as been signed b	Completed by							an autopsy rmed?	available	utopsy lindings a prior to tion of cause
The page	Com						LEC	Yes 2□No		2 No
Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical axaminer? 1)∑N/es 2 □ No	Hospital: 1 ☐ Inpatient 2 🗓	XR/Outpatient 3□	DOA Ot	hor-	ath (Check only of		ner /Snacihi)	
	on: T	27. Manner of Death 1 ☑(Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?		how injury occur		1 8
r Attenter deat	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, street, lactory)		Yes 2 □ No	281. Location (City or To	Street and Numb vn, State)	ber or Rural Rou	te Number,
Hospita 14 hours Funeral tely fille	edical C		ysician: To the best of my kno liner: On the basis of examina and manner stated.							
within 2 To the	Mec	29b. Signature and title of certifier	and marrier stated.	2		se number		29d. Date signe		
		30. Name and address of parson who	A VLaco	MO (Type Print)	•	O.C.M.E.		JULY	28,	1999
		Stephen S. R.	adentz, 111	Penn Stre	et,	Baltimore	e, Maryl	and 2120	01	
Sta		31. Date filed (Month, Day, Year)	32. Registrar'a Signa	ature						

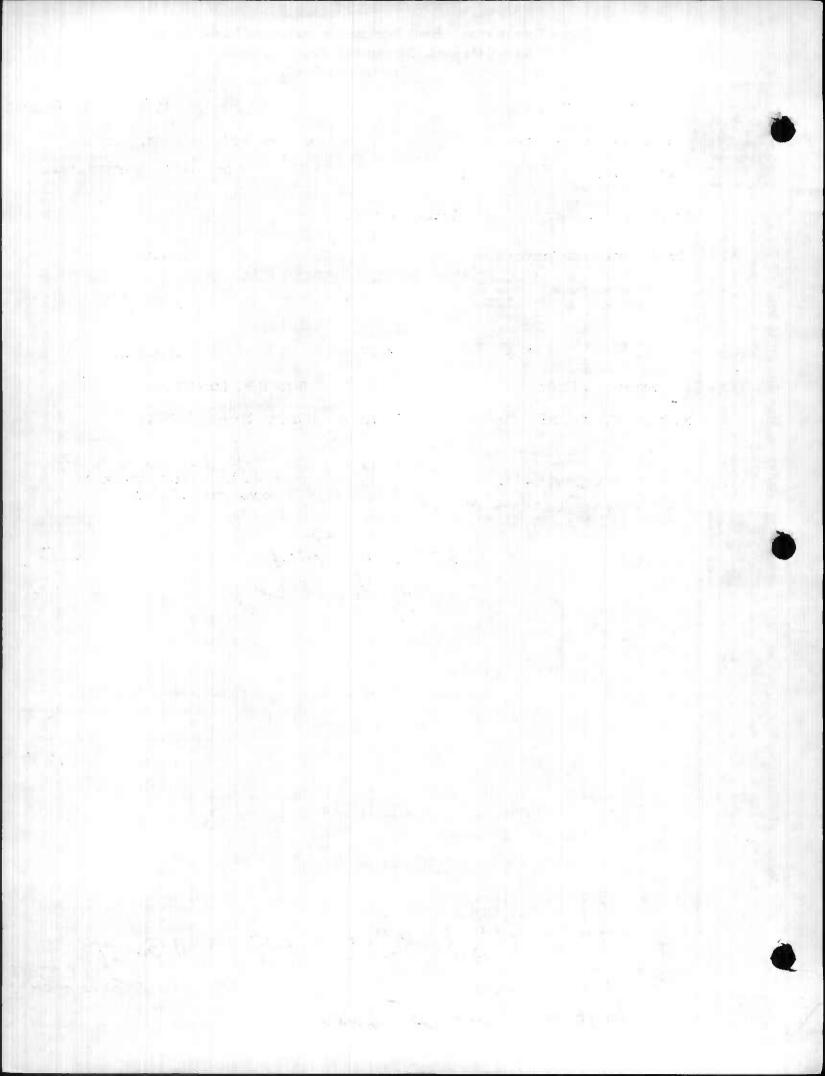


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Daath 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Month **Physician** 3:14 AM Mary Therese Caccivio July 30, 1999 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23025 Esperanza Drive Lexington Park St. Mary's If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. May 12 8 9 1930 5. Social Security Number 9. Birthplace (Stata or Foreign 7. Aga (In yrs. last birthday) Funeral Months 1□M 2₽F Massachusetts 013-22-9756 Yrs. 69 Director 10a. Sieta
10a. Si-Usual Rasidanca of Dacedant permit. Pages 1 end 2 should be filled within 72 hours after death with the Meryland Department of Health and Mental Hyglene. Important: if fram 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, in Mexical Example must be not if a marked page. 10b. County 10c. City, Town or Location 10d. Insida City Limits Lexington Park St. Mary's 1 Yas No 10a. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 23025 Esperenza Drive 20653 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No if Yas, Giva Yaar or Dalas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married Specify: White 1 Yas XX No Specify by 3 Widowed Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b Kind of Business/Industry Collega (1-4or 5+) Elamantary/Secondary (0-12) Teacher Education 18. Mothar's Nama (First, Middla, Maldan Sumama) 17. Fathar's Name (First, Middla, Last) Joseph B. Elliott Hannah M. Loosemore 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) BethAnne T. Caccivio, Daughter 258 Park Lane Lusby, Maryland 20657 20b. Piace of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 8/2/99 ST MARY CITY, MD 4 □ Donation 5 □ Other (Specify) ST JAMES CHURCH CEM Wells-Hawkins, Montague 21. Signature of Funa al Sarvio 22. Nama and Addrass of Facility P.O. Box62908, Washington, DC 20019 MD1188 23a. Part1. Entar the dimast, or complicated that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificete be axecuted physician end the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a equance of) Division of Vital Records, P.O. Box 68760 Physician/Medical that initiated avants rasulting in death) Last Dua to (or as a consequence of) 88 980 signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undariying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to been si 24a. Was an autopsy performed? Completed certificate has b 1 Yas 2 N 1 ☐ Yas 2 ☐ No or Attending Physician; director. 25. Was case referred to medical axaminar? Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Gasidance 6 Other (Specify) 10 1 ☐ Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accidant 5 Panding 1 Yas 2 No Invastigation after death. Director: A 6 Could not be datarmined 28a. Piace of injury - At homa, farm, straat, factory, office building, etc. (Specify) 3 ☐ Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 24 hours after Funeral Dire letely filled in b Hospital 1/2 Centifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Description of the basis of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a, Cartifier edical ical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner/stated. (Check only one) within 2 To the 29b. Signatura and title 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed cad of death (Item 23a) (Type, Print) ARBO 24635 TARES BEAR MED CTR JAM th, Day, Year) 31. Data filed (Mo Registrar's Signature

Registrar

State



	e (First, Middle, L						2. Date of De			3. Time of Death
Petro						lb. City, Town, or L	L	13, Day 1999		12:23 PM
4a Facility Name (I			er)			Lanham	ocation of Deati	, , , , , , , , , , , , , , , , , , , ,	e Geor	ge's
5. Social Security N Unknown		Sex 7.	Age (In yrs. I 67	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da March	th ly ₃ ^{V_f(ar)} 193	9. Birthplac 2. Country	e (State or Foreign latemala
Usual Residence of	Decedent 10b, County		10c City	, Town or Loc	ation			, 1,720	10d	. Inside City Limits
Maryland		George's	Tou. Only		ollege P	ark			100	1 ☐ Yes 2 No
10e. Street and Nu		000180			10f. Zip Code			10g. Citizen of \	What Country	n
5001 K	enesaw	Street			20740			Guate	mala	
11. Marital Status	chegaw	12. Was Decede	2	S. 13. W		ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No		e - American	
1 ☐ Never Marr 3 ☑ Widowed	ed 2 Married 4 Divorced	1 Yes 2 If Yes, Give Year or Date	ĭ€No						" Hispa	
(Sner	15. Decedent's E	ducation		16a. Decede	nt's Usual Occup	ation during most of work	rina	16b. Kind of B	usin <i>e</i> ss/Indu	stry
Elementary/Seco	T	College (1-4	or 5+)	House	O NOT use retired	0	-			
17. Father's Name	(First Middle Lee	1)		nouse	,,110	18. Mother's Nam	e (First Middle	. Maiden Suman	ne)	
Unkno		,					ca Cabre		1	
19a. Informant's N		(Type, Print)		19b. Mailing	Address (Street	and Number or Rui			State, Zip C	ode)
Eladio He	rnandez	Cabrera	Son	5001	Kenesaw	Street (College	Park, M	lary1ar	nd 20740
20a. Method of Dis			1 4	lace of Disposi	steer or other plac	- I	Date	20c.·Location -	City or Town	n, State
	☐Cremation 3 [5☐Other (Speci	Removal from Sta	Mar Mar	yland	National	Cemetery	4/19/9	9 Laurel	. Mary	land
21. Signature of Fu	non-Service Lige	nsee		22.	Name and Addre	ss of Facility W. I	H. Bacon	n Funera	1 Home	2
Man	X	6.81.1	M0118	3/1		Street N.		shington		
23a. Pert1. Enter	ne disease, or con	plications that cause on each	sed the death	. Do not enter	the mode of dyin	g, such es cardiac	or respiratory a	rrest,	i A	pproximate nterval Between
aroux, or riod	(lumpro. Cast orny	One cause on each	11 III 10.						C	Inset end Death
Immediate Cause disease or condition	Final n		NTR	ACRAN	IAL	Hemon	Roge		2	1-3 days
resulting in death)			Due to (or	r es e consequ	ence of):		0		1	
		b							<u> </u>	
Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nditions, imediate		Due to (or	r es a consequ	ence of):					
Cause (Disease or that initiated events	rlying injury	c	Dun to for							
resulting in death)	ast		Due to (or	as e conseque	ence or):				1	
		d		-						
Part II. Other signif	icant conditions	contributing to deat	but not resu	ilting in the und	lerlying cause giv	en in Part I.	23b. Did	tobacco use co	ntribute to t	he cause of death?
(22	disor		1.044			10	Yes 2□ No	3 Probe	bly 4 Unknown
	er june	CU130-						L.	1	Craw College (ULA)
								an autopsy ormed?	aveil	autopsy findings able prior to oletion of cause
									of de	ath?
							10	Yes 2 No	10'	Yes 2□ No
25. Was case refer examiner?		Hospital: V.			o Oth	26. Place of Deet				
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1∕⊠Natural 2 ☐ Accident	5 Pending investigation	(Month,	Day Year)	Injury	28c. Injur Wor M 1	k? Yes 2 □ No				
3 ☐ Suicide	6 Could not be	28e. Place of			et, factory, office	;		Street and Numb	per or Rural I	Route Number,
4 ☐ Homicide	dotominio	building,	etc. (Specify)		- 4	.: City or To	wn, State)		
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29b. Signature and	fitle of cartifier	Q ,	statod.		29c. Licens	e number		29d. Date signe	d (Month, De	ay, Year)
	Salsa	Jan	MI)	D	0534	11	APRI	L 14	1999
	U1. 475									
30. Name and adds	ass of parson who	completed cause of	of death (Item	23a) (Type P	rint)					
30. Name and addr	ess of person who Shesadri	completed cause of		23a) (Type, P		# [0]	3 13	Sovie	MD	20716

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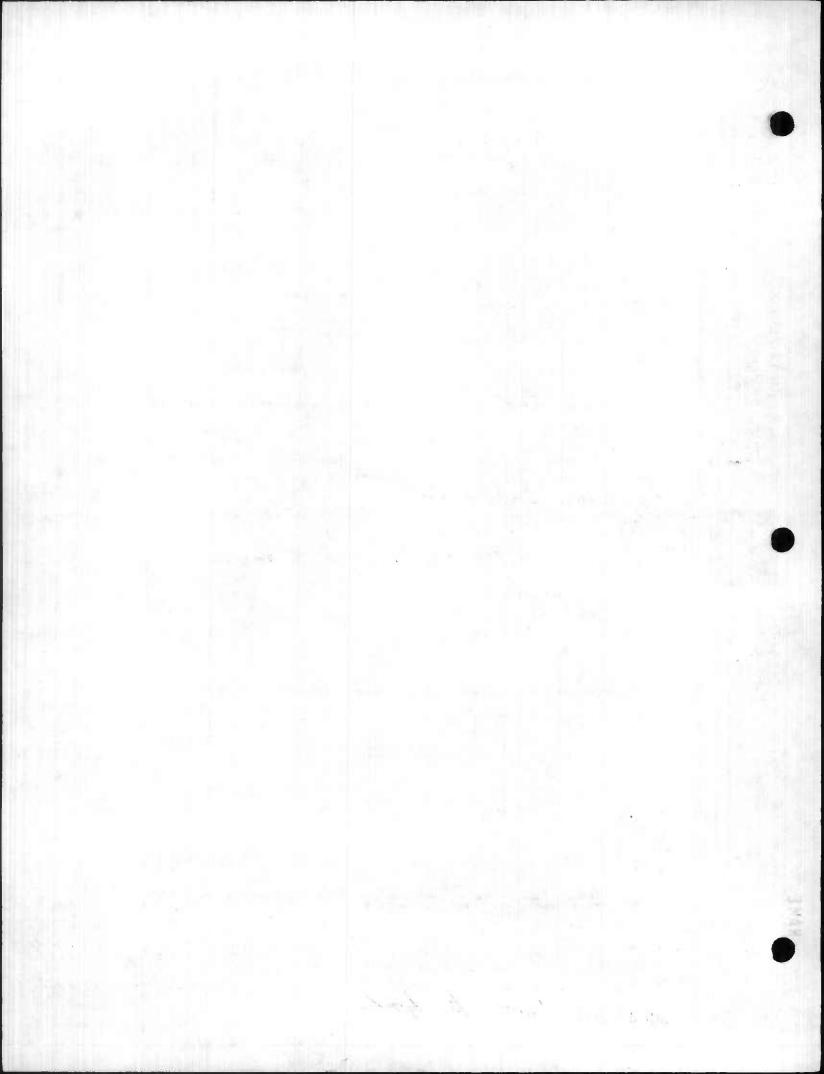
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State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 40AM Ann Louise Carey 27 JULY /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Baltimore Hospital **Baltimore City** If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sax Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Yrs. Director 79 382-16-2607 Illinois September 11, 1919 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. toside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yas 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21043 U.S.A Nome 23a 3300 North Ridge Road Funeral death 12. Wes Decedent Evar in U,S. Armed Forces? 1 Yas 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notr Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, etc. 11. Marital Status 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1□ Yas 2NNo Specify: by White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within innert of Health and Mental Hygiene. Int: If Nem 27 Is marked other than "I Education College (1-4or 5+) Elementery/Secondery (0-12) Teacher 17. Fathar's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be George Baldwin Marie Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other treu once. 5 Seminole Ave. Catonsville, Maryland 21228 Mr. P. Michael Carey Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/28/99 Baltimore, Maryland Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MO0535 Part 1. Enter the disease, o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feitura. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Fine) Lung Piscaso disaasa or condition resulting in death) Examiner Due to (or as a consequence of): Examine physician and s the burial-transit that the death certificate be executed Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to for as a consequence of i Box 68760. Physician/Medical Due to (or as a consequence of): 980 Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 12 Yes 2 No 3 Probably 4 Unknown signed i Records. 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2KNo Division of Vitai 25. Wes case referred to medical axaminar? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yes 20 No Medical Certification: To Impatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Panding Investigation or Attending Netural death. 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify) 124 hours after of Funeral Direct 4 Homlcide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifier To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. To the F within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D50727 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) St. Agres Her 900 Caton Ave Baltomon MD 21229 7:16 Gallagher Hospita 31. Date filed (Month, Day, Year) State

DHMH 16 Ray 6/95

Registrar

JUL 3 0 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death July 2 3 gray 1999 4:30 am Paul Kinsey Cummins 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 3002 Tanbark Lane Bowie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) XX M 2□ F Days Months Hours Min. Oct. 577-12-3279 78 Virginia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Bowie Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3002 Tanbark Lane 20715 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 ☐ Yes 200 No 1 Never Married 2 Married White 1 Yas ZINo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Consultant Water Treatment 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Ruth Fowler Paul K. Cummins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3002 Tanbark Lane, Bowie, MD 20715 Doris S. Cummins (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/31 Davidsonville, MD Davidsonville U.M. Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. mao Ridgely Ave., Annapolis, MD 21401 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) with gangrene BY Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? TO Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes No TI Yes 252No 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 26a. Date of Injury (Month, Dey Year) 28d. Describe how trijury occurred 28b. Time of 28c. tnjury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 281. Location (Street end Number or Rural Route Number, City or Town, Stete)

The law requires that the death certificate be axecuted Box 68760. P.O. Records. Division of Vital or Attending Physician: After this within 24 hours after death. To the Funeral Director: A

Hospital

To the

Physician

/Medical

Examiner

Director

Funeral

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r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at

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21215-0020

Baltimore, Maryland

permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic avant

Physician /Medical

Examiner

Sequentially list conditions, if any, teading to immadiate ceuse. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last by Physician/Medical 88 Completed Be 1 Yes 3€ No Medical Certification: To 27. Manner of Death 1 Watural 2 Accident 3 Suicida filled in by

29a. Certifier (Check only one)

29b. Signature and title of certifian

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

1855/05/40

32. Registrar's Signature

Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Was case referred to medical examiner? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 Homicide

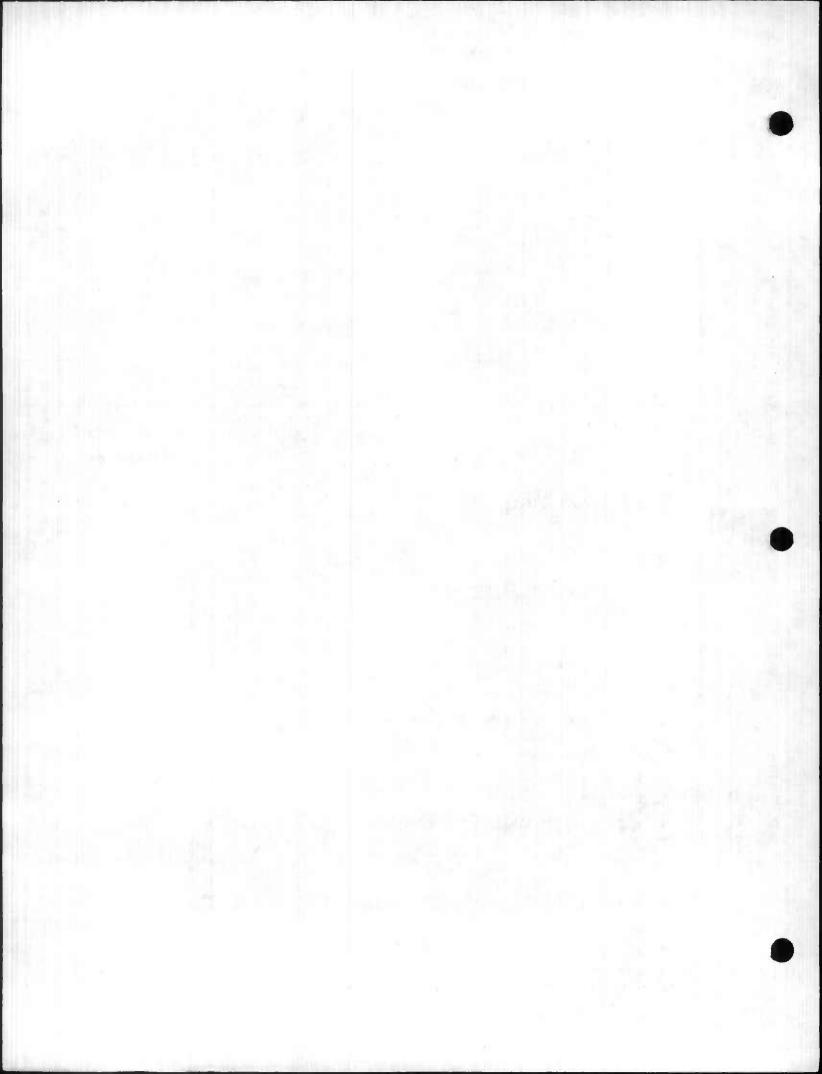
State Registrar Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

29d. Date signed (Month, Dev. Year)

Cochrane Or, Annapolis, M21401

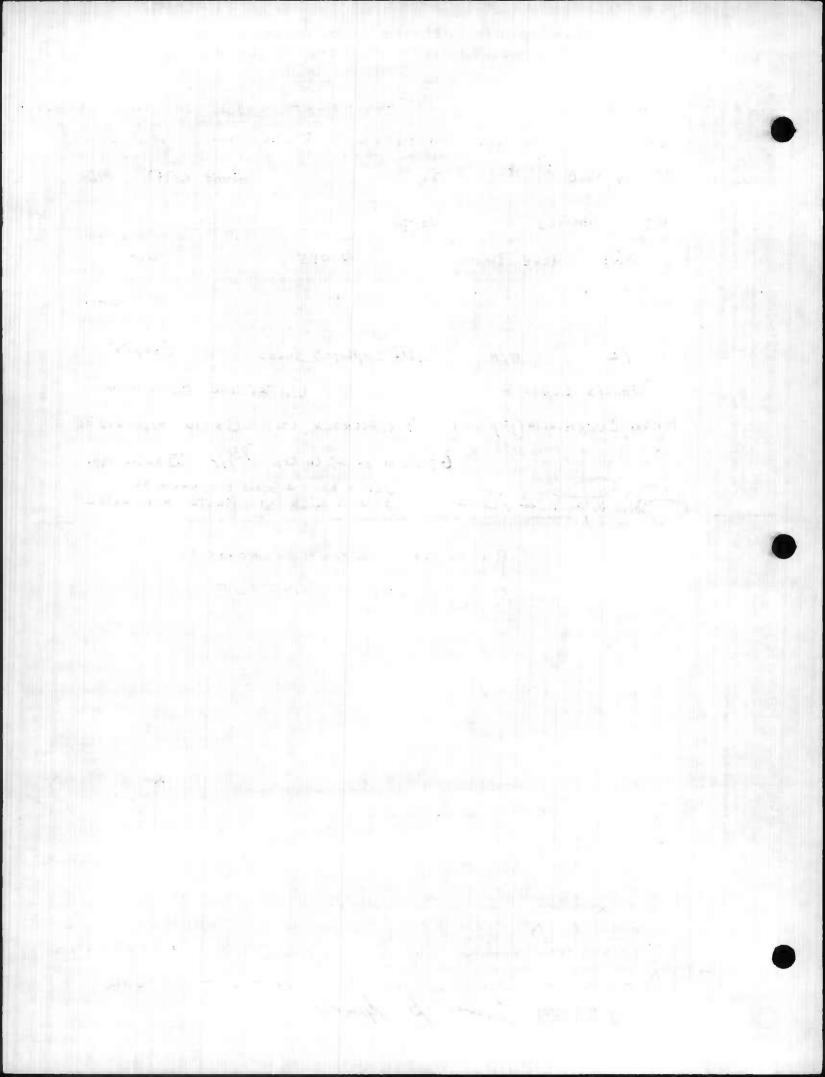


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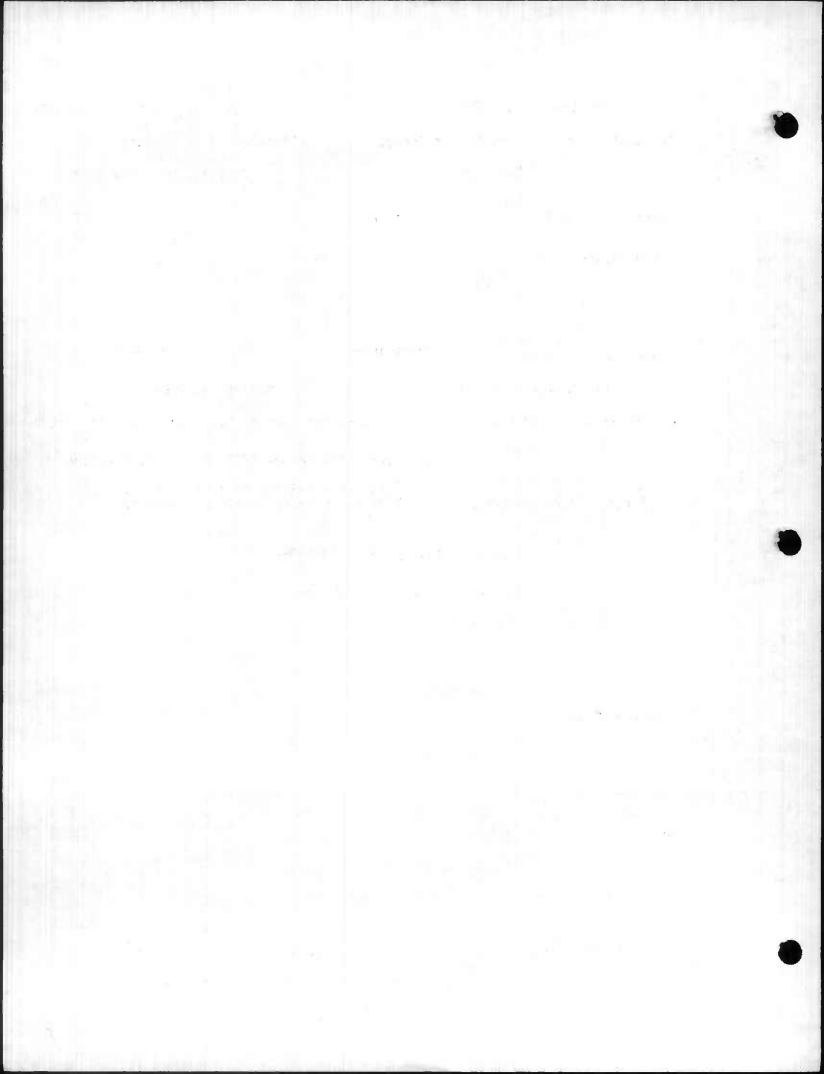
DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Dey, Year)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Mary		Certificate of			Reg. No.	3 23969			
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death			
Ų,	/Medic		Dorothy A. Dur	nn			July 2	25, 1999	11:00 PM			
	Examir	ner	4e. Facility Neme (If not institution, give street and number)			b. City, Town, or						
L			The Wesley Home 2211 W. Rog 5. Social Security Number 6. Sex 7. Age (//	gers Av In <i>yrs. l</i> as <i>t birth</i>		Baltimo			1/A			
0	Funeral Director		USUAL Residence of Decedent		Months Days	Hours Min.	8. Date of Birth (Month, Day July 26	7, Year) 5,1899	Birthplace (State or Foreign Country) New York	n		
	and tand			Oc. City, Town	or Location				10d. Inside City Limits	3		
	Mary Hear	tor	Maryland N/A	Ba1	timore				X1XXYes 2□ No)		
	or 28,	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of V	Vhat Country?	-		
	23a d	raic	2211 W. Rogers Avenue		2120	9		USA				
	terms terms	Funeral	11. Marital Status 12. Was Decedent Eve	or in U,S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Raci	14. Raca - American Indien, Bleck, White, etc.			
Maryland 21215-0020	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examinet must be notified at	by	1 Never Merried 2 Married 1 Yes, 2 No 3 Widowed 4 Divorced 1 Yes, Give Yaar or Dates:		1 ☐ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Specify:	- Louis Villa	Specify	111 1 4			
2-0	hin 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. [Decedent's Usual Occup Give kind of work done life. DO NOT use retired	ation duning most of wor	rkina	16b. Kind of Bu	siness/Industry			
121	d within lene. r than "	mpi	Elementary/Secondery (0-12) Collega (1-4or 5+)		iile. DO NOT use retired memaker	1)		Own H	Home			
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an	od ala	To Be	Herlin Manley Appelgat	- ρ					-,			
ary	d 2 should th and Mer 7 is marks traumatic	-	19a. Informant's Name/Relationship (Type, Print)		State, Zip Code)							
	17 E		19a. Informant's Name/Relationship (Type, Print) The Wesley Home Guardian 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, State 2211 W. Rogers Avenue, Baltimore, Mar									
Baltimore,	of Heelt of Heelt if Item 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Piace of I cemetery.	Disposition (Name of crematory or other place	e) torv	Date	20c. Location -	City or Town, Stete			
Ei	ment ment tant:		4 □ Donation 5 □ Other (Specify)		Washingtor		7/27/99	Laurel,	Maryland			
Bal	permit. Pages 1 ar Department of Hee Important: if Item 2 any Injury or other ance.		21. Signature of Funeral Service Licensee	1)	22. Name end Addre Burgee-Her	ss-Seitz						
			23a. Part 1. Enter the diseasa, or complications that caused the shock, of heart failure. List only one cause on each lina.	death. Do no	3631 Falls of entar the mode of dyln	g, such as cardlad	or respiratory en	e, Mary I	Approximate Interval Between			
7	Physician								Onset and Deeth			
	/Medical Examiner		Immediata Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)	VASCI	ILAR DU	seuse						
		er	Due	e to (or as a co	insequenca of):							
	uted d ensit	Examiner	Samuel Market and Miles	ETU /	east Blo	ve.				_		
o,	exac en en riel-tr		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0-1 1	1							
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Вох	thet the death cert ed by the ettending detached for use	Physician/M	0.									
	0 00	ysic	Pert II. Other significant conditions contributing to death but no	ot resulting in t	he underlying cause giv	en in Part I.	23b. Dld 1	obacco use cor	tribute to the cause of death	?		
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of	g Phy er this seral		27. Manner of Death 28a. Date of Injury	28b. Tir	ne of 28c. Injur		28d. Describe h			_		
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Division	if or Attending Phistie death. Director: After this din by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (5	- At home, fem Specify)	n, street, fectory, office		28f. Location (S City or Tow		er or Rural Route Number,			
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) Check only one) Check only one) Check only one)	amination and/	daath occurred at the tin or investigation, in my o	ne, date and placa pinion, death occu	, and due to the o rred at the time, o	ause(s) end ma date and placa, a	nner as stated. and due to the ceuse(s)			
	To the within 2 To the comple	Me	29b. Signeture and title of sertifier		29c. Licens	e number		29d. Date signed	(Month, Day, Year)	-		
R	->-0		R. Lette nus.		7	1111/		7/1/	199			
		}	30. Nama and address of person who complated causa of death	n (Item 23a) (T	ype, Print)	altex		100		_		
				8508	ype, Print) BANK 57	BAZ 7	o, mel.	212	24			
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/Medical

Examiner

The law requires that the death certificate be axecuted

Box 68760

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Division of Vital Hospital or Attending Physician: buriel-transit

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To the Funeral Director: All completely filled in by the fu

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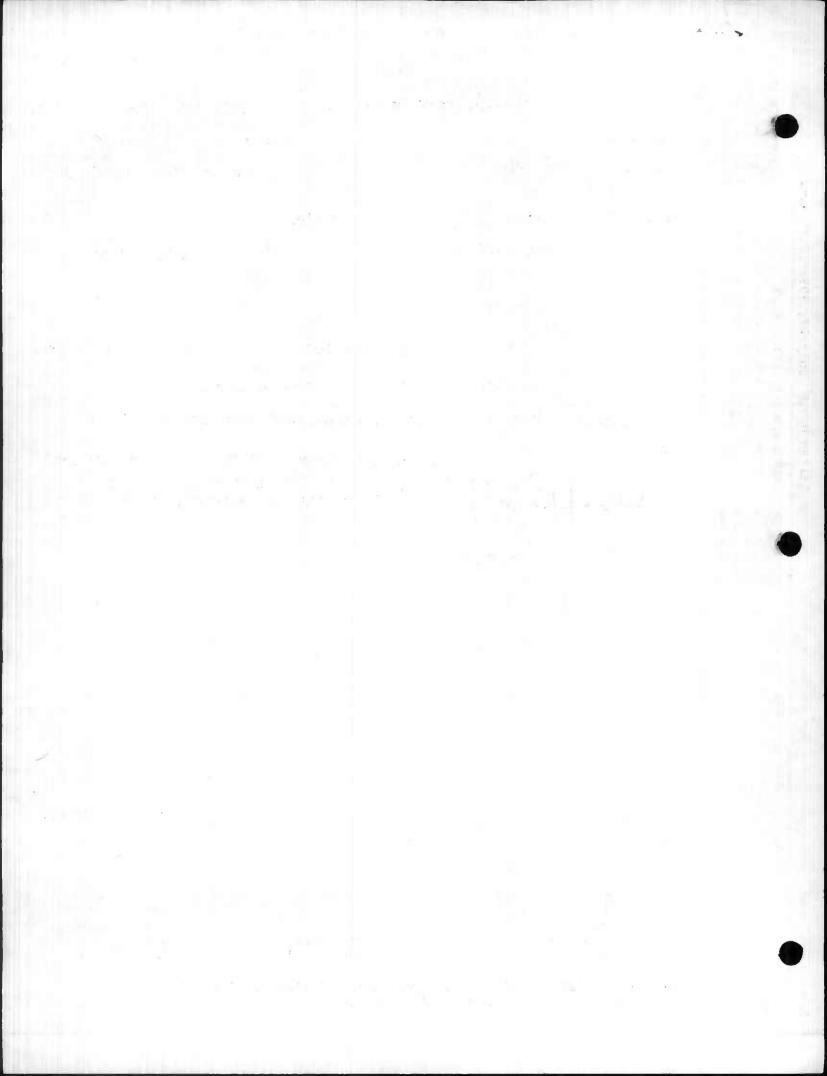
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State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day William Joseph Davis Jr. 27, July 10:15 a.m. /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Towson Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) May 10, 1918 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1**⊠**M 2□ F 553-10-8111 81 Yrs. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Md. 1 Tyes 2 NO Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 7431 Greenbank Road United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No if Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Coilege (1-4or 5+) Beth. Steel Shipyard Superintendent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Sumama) Be WilliamJ. Davis Sr. Frances Burroughs 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) (Wife) 7431 Greenbank Road Baltimore, Md. Marie A. Davis 20b. Piaca of Disposition (Nema of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery 7/31/99 Baltimore Maryland 21. Signature of Funeral Service Licansee Milton J Knight Jr 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death immediate Cause (Fine) disease or condition resulting in death) MESOTHELOMA Due to (or as a consequence ot): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tee 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? TA Yes 2 No IL Yes 20 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Deeth 28e. Date of injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicide 150 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piace, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end piace, and due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD TIMONIUM, MD 21093

State Registrar

31. Date filed (MTT)

2300 DULANEY VALLEY RD. 32. Registrant Signature



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Carol May Ferris 1999 JULY 12:30 PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 905 Kingston Road Baltimore Baltimore 5. Social Security Number if Under 1 Year if Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign Deys 1 M 2 TF 503-30-7316 65 South Dakota Yrs Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes &☐ No Baltimore Baltimore 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 528 Castle Dr. USA 14. Rece - American Indian, Black, White, etc. Apt. D 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
tf Yes, Giva
Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Wivorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Bustness/Industry Elementary/Secondery (0-12) Collage (1-4or 5+) Self Employed Artist Art 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) William Swartz Claire Unk. 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Kingston Rd. Baltimore, MD 21212

20b. Plece of Disposition (Name of cometary, cramatory or other plece)

20c. Location - Company Mary E. Jacobson/daughter 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriet 2 【Cremation 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 7/80/99 Baltimore, MD 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 21. Signature anaral Service Licensee Edward A. Cresbrchik 299 Frederick Rd. Balti:

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List of the one cause on each line. Approximete tritervat Between Onset end Death tmmediate Ceuse (Final disease or condition resulting in death) Due to (or es a consequance of): Sequentielty list conditions, if any, teeding to Immediate cause. Enter Underlying Ceuse (Disease or trijury thet Initiated evants resulting in death) Lest Due to (or as e consequence of) Due to (or es e consequence of): 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

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nem 27 is marked other than "natural", or items 23s or 28s4 sho other traumatic event, the Medical Examiner must be notified at

should be filed within 72 hours after of Mental Hygiane.

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permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: if item 27 is marked othe any Injury or other traumaits

Baltimore, Maryland 21215-0020

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Examiner buriel-transit Physician/Medical by Completed Be L_o Certification:

and physicien a Box 68760. P.0. á been signed to should be det Records, page 2 certificate Division of Vital To the Hospital or Attending Physician: within 24 hours eftar deeth.

To the Funeral Director: After this certifica

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medicat 26. Pleca of Death (Check only one) Othar: 4 Nursing Home 5 Residence Nother (Specify) Daughter's 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Data of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Coutd not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At home, ferm, street, factory, office building, etc. (Spacify) 4 Homictde Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, deta end place, and due to the ceuse(s) and menner stated. 29a. Certifier

State Registrar

Medical

29b. Signeture end title of certifier

30. Name end eddress

DHMH 16 Rev 6/95

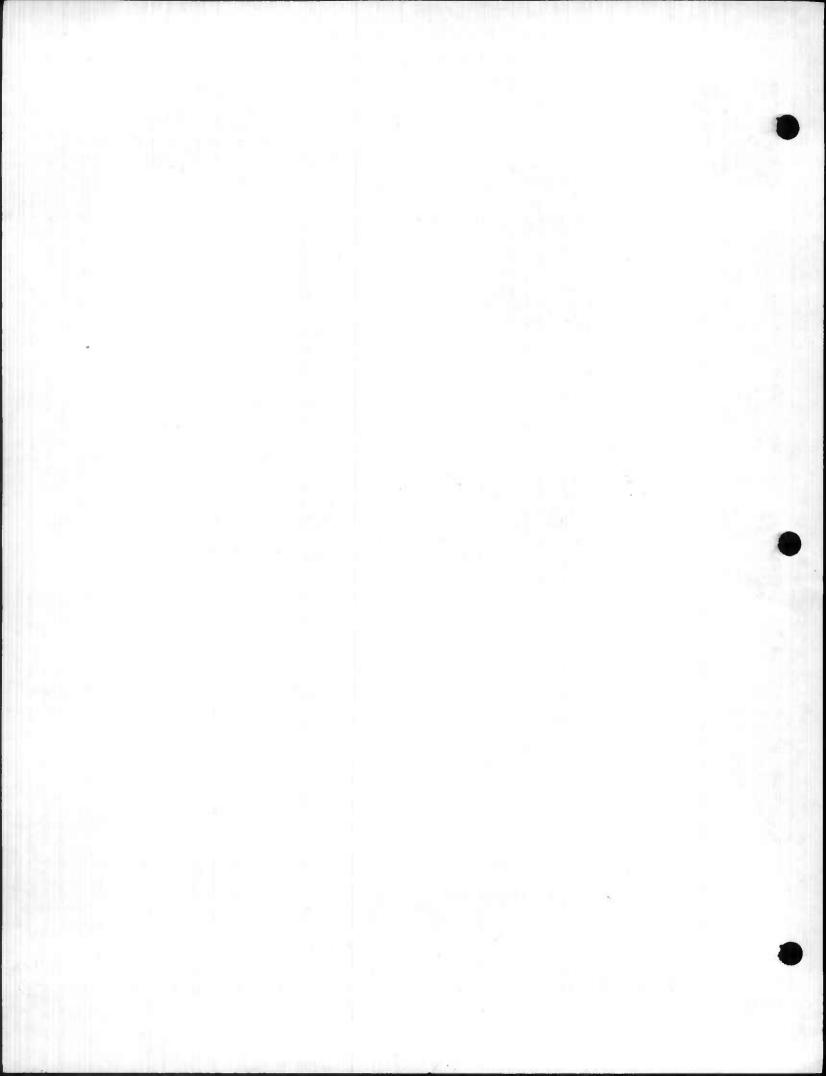
2. Registrar's Signeture

29c. License number

29d. Dete signed (Manth, Day, Year)

KOLILWETH DR Ste 202

Residence



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death FRICIA FARhOR 15:50 July 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death BALTIMORE of mary lang 1 ms If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthdey) 42 Yrs. 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplaca (Steta or Foreign Country) 10M X0F 216-72-5936 FEB 19 Maryland Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits X□ Yas 2□ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2243 Cedley Street 21230 USA 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 Nevar Married 2 Merried 1 ☐ Yes 2♥ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Laborer Construction 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Richard Graczyk Mary Katherine Braden 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Deborah Ann Force/sister Rte.3 Box 5628 Berkley Springs, WV 25411 20b. Plece of Disposition (Name of cemetery, crametory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Steta 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 7/30/99 Baltimore, MD 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signatu of neral Service in n de A. Gregorchik Edward 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease of promplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert tellure. List miy one ceuse on each lina. Immediate Cause (Final disease or condition resulting in deeth) urmous cell Lung concer - metastatic Due to (or es a consequence of): Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): NEUMONIA Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yea 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy

Physician /Medical **Examiner**

Physician

/Medical

Examiner

MD

Director

Funeral

by

Completed

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Madical Experient must be notified at

72 hours after

permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiena. Important: If fem 27 is marked other than "natural", or leny injury or other traumatic event.

altimore, Maryland 21215-0020

Box 68760

P.O.

Records.

Division of Vital

USB BS

certificata be axecuted Physician/Medical attending s been signed by to should be detach þ Completed certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 10 edical Certification:

1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending invastigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29s. Cartifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29c. License number

29b. Signatura and little of certifiar

29d. Dete signed (Month, Day, Year)

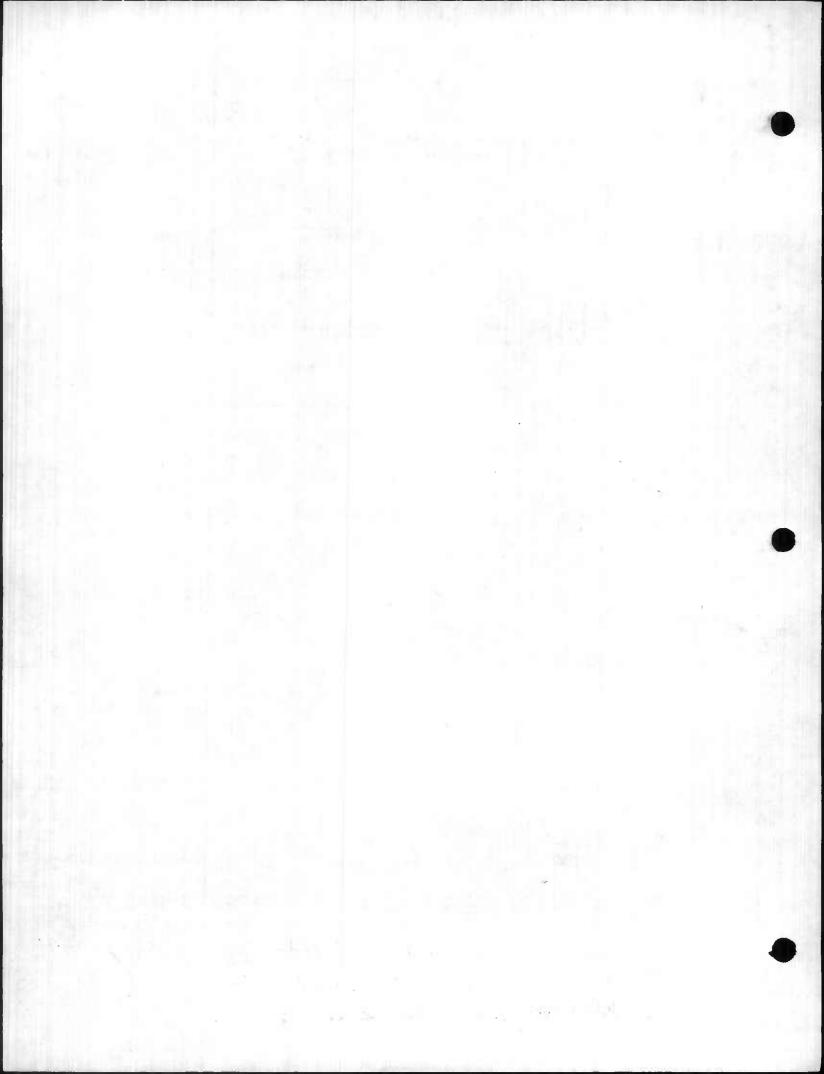
ss of person who completed cause of death (Item 23a) (Type, Print) Street

State

31. Date tiled (Mon

32. Registrar's Signeture

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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		30. Name	and addre	ess of person who	completed cause	of deeth (Ite	em 23a) (Type, Print)	95	01010	1 Annu	Opp	lic	RO
	State Registrar	31. Date fi	led (Monti	h, Dey, Year) JUL 3 0	32. Rev	pistreir's Sign	neture	<i>b</i> .	Spor	Ks	Elli	00/1	city	W 2104-3

E MATTER VISITE :

State Registrar

DHMH 16 Rev 6/95

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30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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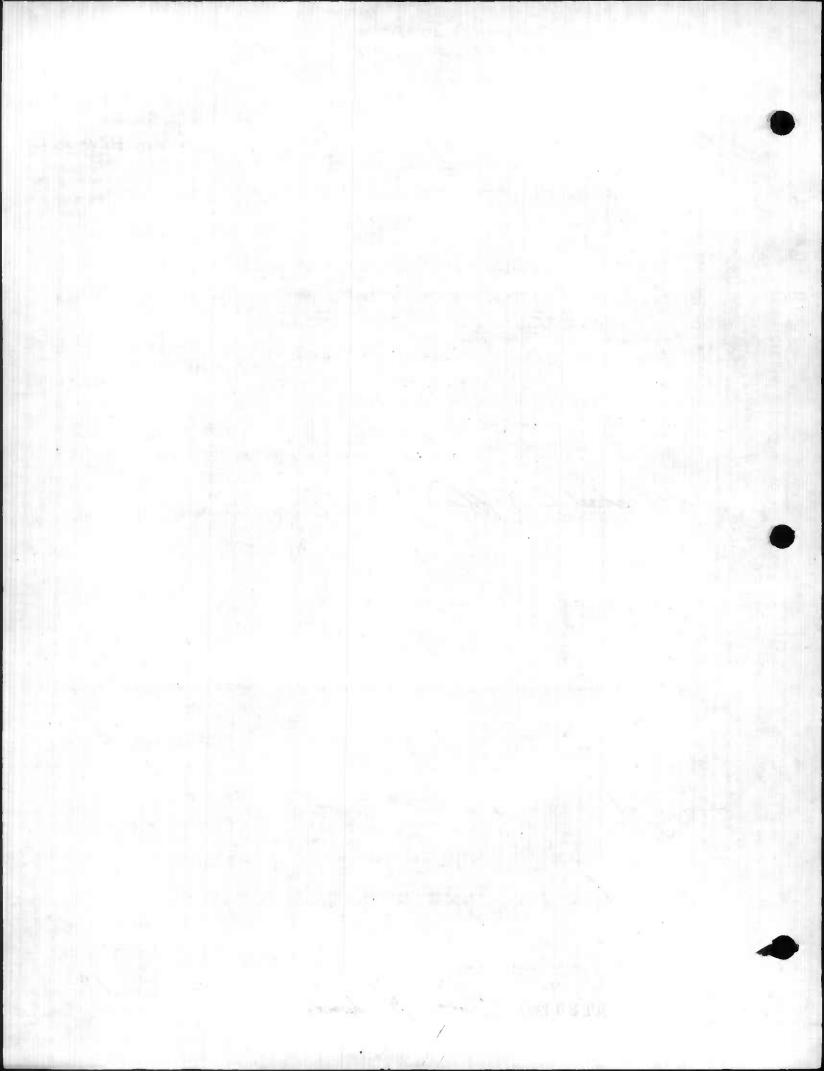
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32. Registrer's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 2 3 9 7 5

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/Medical Examiner	4a Facility Neme (If not institution					1	tb. City, To	wn, or Lo	cation of Deat	h 4c. Count	y of Death			
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Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under		If Under	24 Hrs.	8. Date of Bir	th		olece (State c	or Foreig	
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7 la marke traumatic To	19a. Informant's Name/Relations	hip (Type, Print)	1	9b. Meilir	ng Address	(Street	and Numbe	er or Rura	! Route Numb	er, City or Town	, State, Zip	Code)		
Health em 27 I rther tru	Cynthia Cher	ry-Moth	er	754	Cari	col	l Str	ceet	, Bal	timore	Md	21230		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 1.35 Am DOROTHY GRANESE 1999 July 26 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth ARUNISEL GEEN BURNIE North ARUNISEL HOSPITAL ANHE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5 Social Security Number Birthplece (Stete or Foreign Country) 7. Age (In vrs. last birthdev) Months 1 M 2 N F Yrs. 66 304-32-2774 DEC. 5. 1932 TENNESSEE Usual Residence of Decedent 10a Stete 10b County 10c. City. Town or Location 10d. Inside City Limits ANNE ARUNDEL LINTHICUM HEIGHTS 1 Yes 2 No MARYLAND 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21090 U.S.A. 620 SHIPLEY ROAD 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Merital Status 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried XX Married 1 ☐ Yes 2√ No Specify: WHITE 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) LAWYERS OFFICE PARALEGAL 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) CROSS SAMUEL TRULA LOWRY 19a. Informent's Neme/Reletionship (Type, Print) (HUSBAND) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 SHIPLEY ROAD, LINTHICUM HEIGHTS, MD. 21090 CARMINE JOSEPH GRANESE, JR. 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete MEADOWRIDGE MEMORIAL PARK 8/2/99 ELKRIDGE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FecilitySINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Ceuse (Finel METASTATIC LUNG CARGNOMA disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): thet initieted events resulting in death) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert ff. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

certificate be executed P.O. Box 68760. Division of Vital Records. Attending Physician: death. or Attendation of the Director: To the Hospital or within 24 hours aft To the Funerel Di completely filled in

> State Registrar

Physician

/Medical

Examiner

Funeral

Director

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Physician /Medical

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29b. Signeture end titie of certifier

JUL 3 0 1999

30. Name and a dress of person who completed cause of death (Item 23e) (Type, Print)

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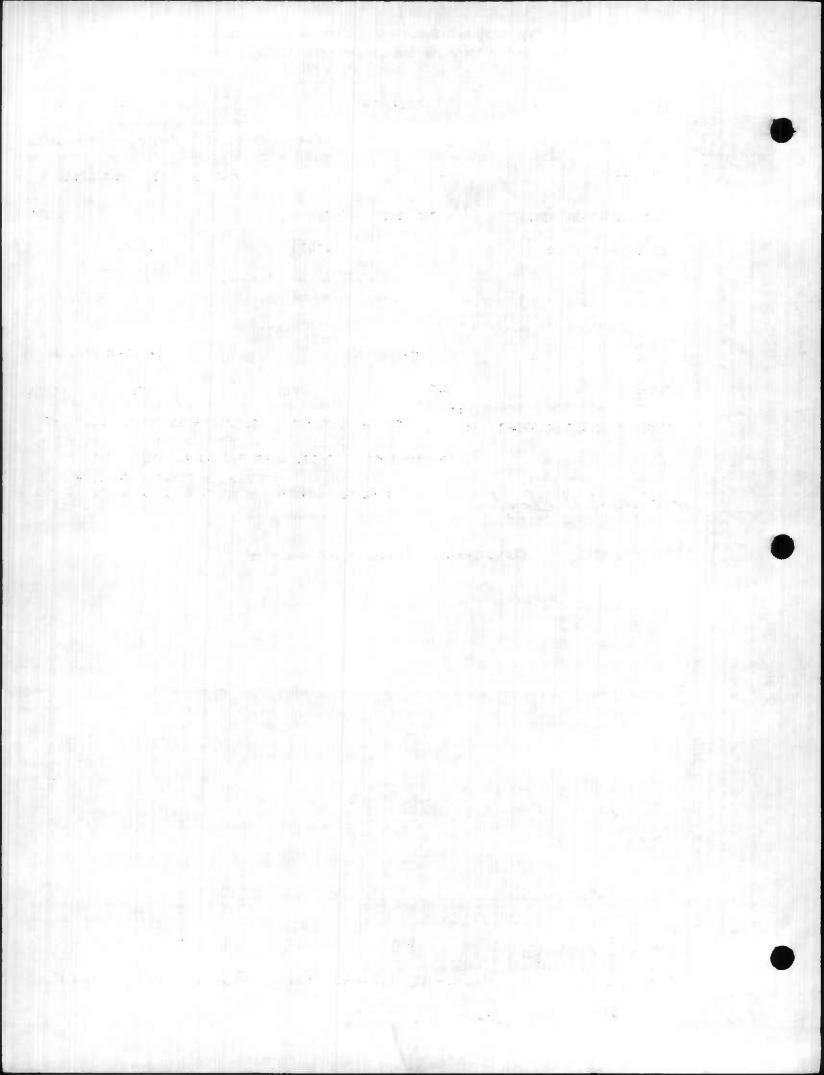
29c. License number

29d. Date signed (Month, Day, Year)

GLEN BARNIE MS 21061

ONABAJO 31. Dete filed (Month, Dey, Yeer)

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of He

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		BON S	SEC	ours	14	OSPIT					MORE	1				
Funeral Director	213	al Security Number 3-60-1403		ox M 2□F	7. Age (In yrs. 45	last birthday) Yrs.	if Under Months	1 Year Deys	If Under 24 Hours	Min.	8. Date of Bi (Month, D Dec • 5	irth a <i>y, Year)</i> , 195	3	9. Birthpl Count Mary 1	ece (State of try) and	or Foreign
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or 28a-1 • De notified Director		reet end Number			ра.	TCIMOL	10f. Zip (Code		-		10g. Citiz	en of V	Vhet Count	try?	
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B. Sparks

Registrar

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GRAYSON, ALICE L se Type or Print in Black indelible ink. Assure All Copies Are Legible. V00002215754 01/19/39 State of Maryland / Department of Health and Mental Hygiene MAURER.SCOTT **CCU F/60** M00185941 07/24/99 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** U:57AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 234 HOWARD COUNTY CENERAL HOSPITAL COLUMBIA HOWARD COUNTY If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 20 F 60 Director 217-36-2898 January 19, 1939 Texas Usual Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or flems 23s or 28s-f short the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Howard Maryland Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A 11232 B Snow Flake Court Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 11 Merital Status filed within 72 hours after Never Married 2 Merried 1 ☐ Yes 2 No If Yes, Give altimore, Maryland 21215-0020 1□ Yes 2 No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced White Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Computer Elementery/Secondery (0-12) College (1-4or 5+) 4+ Operations Manager 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Pages 1 and 2 should be nent of Health and Mental If item 27 is marked or other traumatic av Albert Louis Grayson Clara Tubbs 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 53 Nedsland Ave. Titusville, New Jersey 08560 Ms. Julia Black Mardes Cousin 20b. Plece of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other pleca) 1 Buriel 2 Cremetion 3 Removel from Stete
4 Donetlon 5 Other (Specify) Department of Important: If any injury or 07/29/99 Baltimore, Maryland Metro Crematory 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. lunch M00535 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): The law requires that the death certificata be exact P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Pert tt. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown MITRALVALUE REGURGITATION Division of Vital Records. Be Completed by CHRONIC RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 / No 1 Yes certificata Hospital or Attanding Physician: 1
 24 hours after death.
 Funeral Director: After this certifical 25. Was case referred to medical axaminer? 26. Piace of Deeth (Check only one) Hospitel: 1 ☐ Yes 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 ☑ Netural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, dete and place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the \$ 29c. License number D2990 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifie 0 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

S. MAUPEL MO 9501 OLD ANNAPULLS ELLI COTT CITY MO. 21042 RO

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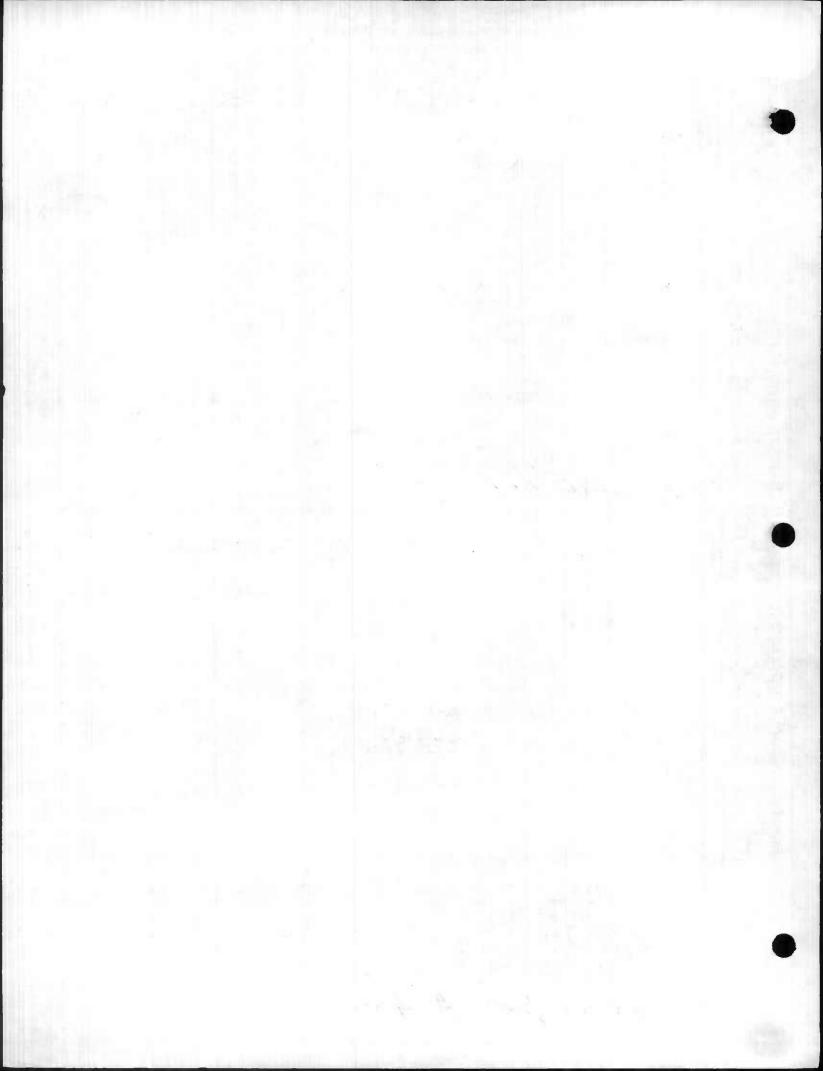
State

Registrar

31. Date filed (Month, Dey, Year)

JUL 3 0 1999

32. Registrer's Signature



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	with	눕		REXEME	מקי	R∩∆D				10f. Zip Code	1218				.S.		try?	
	d 2 should be filed within 72 hours effer death with the Maryland thand Mental Hygiene. 7 Is marked other than "natural", or frems 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified as	Funeral Director	11. Meritei Slelus	KEMBITE		. Was Dec		ver in U.	S. 13.		of Hispanic Origin? (Specify Yes							
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x 68760,	nysk he t	Physician/Medical	Cause (Disease of that initiated event resulting in death)	r injury	c		D	ua to (or	as e consec	quence of):				-				
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Sio	Attending or death. ector: After by the fune	cat	2 ☐ Accident 3 ☐ Suicide	invastiç 8 ☐ Could r	nol he						Yes 2] No		10.				
Division	or Attending Phater death. Director: After this in by the funeral	Certification:	4 ☐ Homicida	daterm		28e. Place build	e of Injur ling, atc.	y - At ho (Specify	ma, ferm, st	reet, factory, offic	e		28f. Location City or T	(Street a	ind Numb ta)	er or Rura	Routa N	umber,
Ī	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	edical Ce	29a. Certifier (Check only	1 Cortifyin 2 Medical	g Physic Examine	lan: To the	s best of	my knov	wledge, deat	noccurred at the vestigation, in my	time, date a	ind place,	and due to the	e cause(s) and ma	nner as st	ated.	in(s)
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	Sta Registr		31. Data filed (Mor	oth, Day, Year)	30	32. F		's Signal	tura	B. A.	pork.							



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** July 25 Day 1999 Yeer Patricia Ruth Glass 8:05PM /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Gilcrest Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) Months 1 □ M 2 🖫 F 404-26-9991 Yrs. 70 Aug. 3, 1928 Kentucky Usuei Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□ Yes 2□No Director Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral U.S.A. 21045 Lane Was Decedent Ever In U,S. Armed Forces? 5471 Sleeping Dog Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 ★Married ☐ Yes 2 🕅 No Yes, Give White 1 ☐ Yes 2X No Specify. by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Aerospace Contract Administrator 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Crossfield Alice Willis 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Sherley B. Glass (Husband) 5471 Sleeping Dog Lane, Columbia, MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 7/29/99 Clarksville, MD 4 Donetion 5 Other (Specify) Columbia Memorial Park 22. Name end Address of Fecility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Acenses 5555 Twin Knolls Road, Columbia, MD 21045 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting In death) . Small cell concer Due to (or es a consequence of): Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Physician/Medicai Due to (or es a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yes 2X No 1 □ Yes 2 □ No Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Rother (Specify) Hospice 1 Yes 2 No Certification: To 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 205265 -16 mo 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 6701 N. Charles St. Prolto und 21204 G-BMC 31. Dete filed (Month, 32 Registrar's Signature

State Registrar

Funeral

Director

"natural", or items 23a or 28a-f shov

Pages 1 and 2 should be filed within 72 hours after to ent of Health and Mental hygiene.
Int: If Item 27 is marked other than "natural", or itee inty or other traumatic event, in a Notice Learnman iny or other traumatic event, in a Notice Learnman.

Physician

Examiner

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page 2 should

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Baltimore, Maryland

Box 68760.

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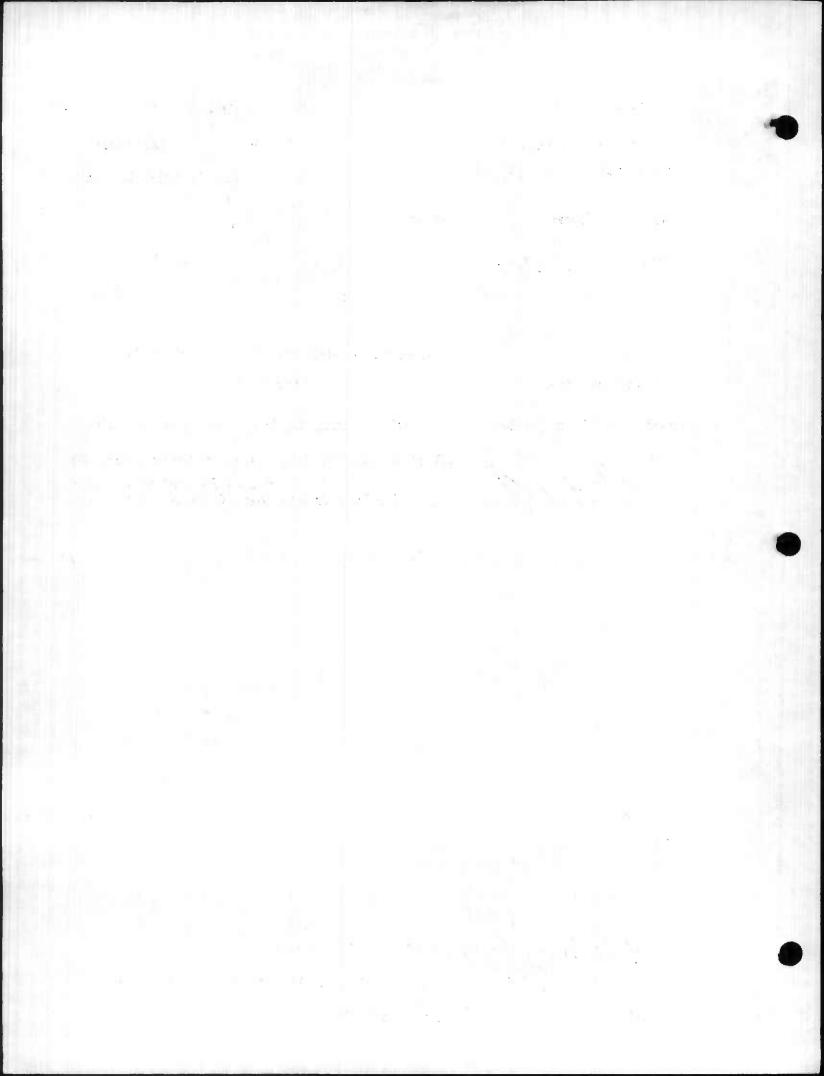
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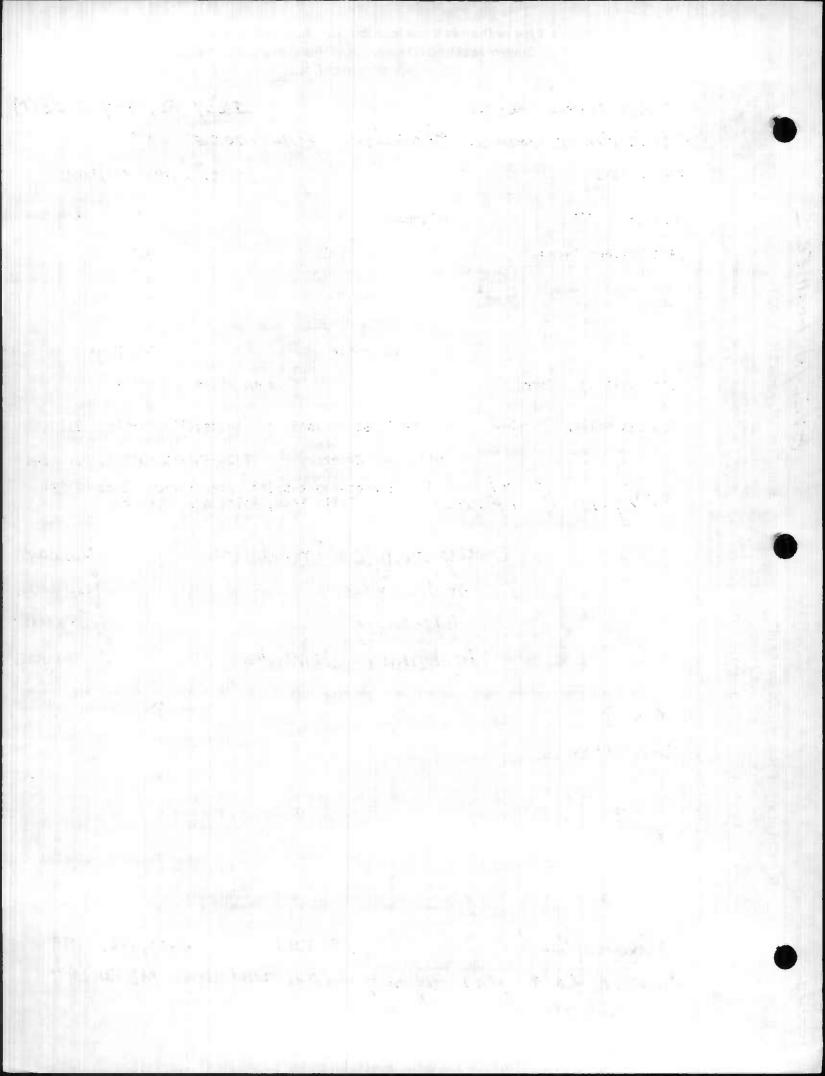
The law requires that the death certificate be



EVELYN HEUBECK

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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23982 Certificate of Death Reg. No. 2. Date of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) **Physician** 26,)u /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 159, and Glen re 0 0 If Under 24 Hrs 5. Social Security Number 216-10-15: H Under 8. Date of Birth (Month, Day 7. Aga (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Days Months Hours 1□M 20 F Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If ham 27 is marked other than "natural", or thema 23a or 28a-f ahow any injury or other traumatic avant. In the second 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Ma 1 Yes 2 □ No Funeral Director nore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Ue. dd del 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yas 2 🕱 No Specify: þ ear 3 Widowed 4 □ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland 17. Fathe 's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be eoral anna Abb. Mailing Address (Street and Number or Rusul Route Number, City or Town, Stete, Zip Code) 199. Informant's Name/Relationship (Type, Print) (Goddaugh 0 20b. Place of Disposition (Nama of cemetery, cremetory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State ery, cremetory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph 2222 V uner al Enter the disclasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart tall, re. List only one cause on each line. Balto. 21216 Approximate Interval Between Onset and Death **Physician** Cancer /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Due to (or aa a consequence of): signed by the attent Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 🗆 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Location (Street end Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Division of Vital Records. or Attending Physician: 24 hours after death. Funeral Director: A completely filled in by Hospital within 2 ş

29b. Signatura and titla of certifian hurl 29c. License number 39127

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. Eutaw AHMED MID

Street-Baltimore MD

Registrar

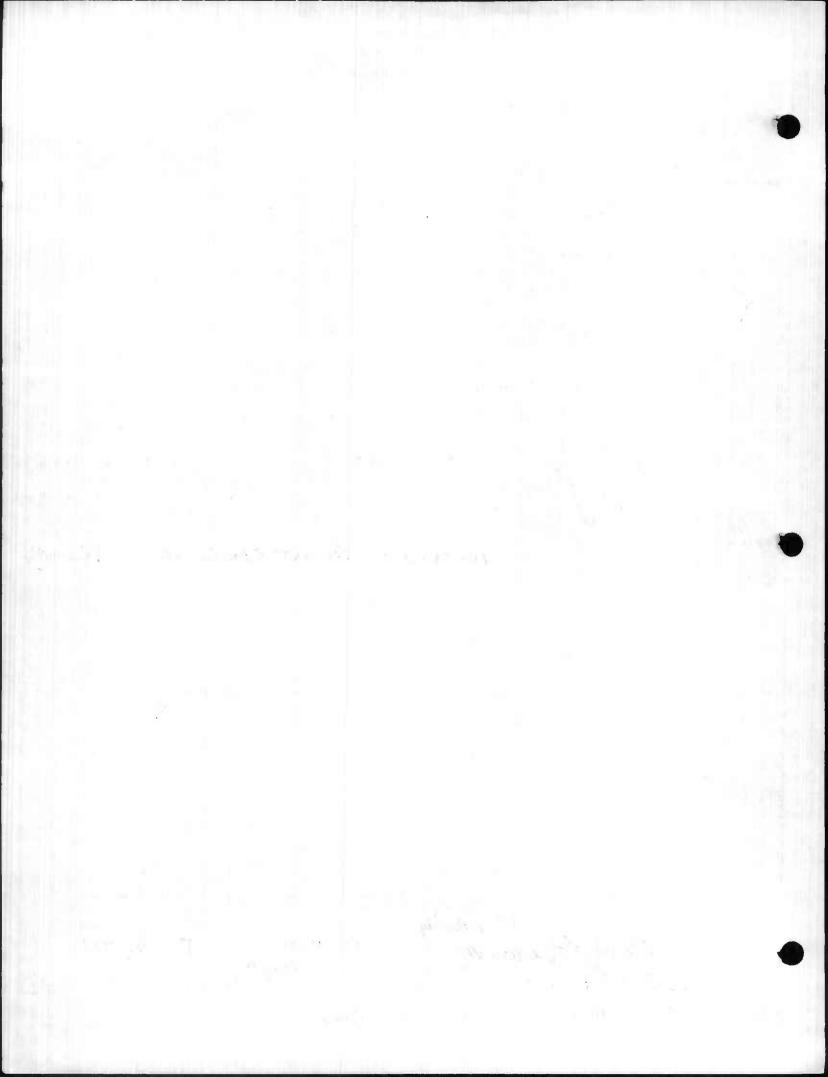
31. Date filed (Month, Day, Year) JUL 3 0 1999

29a. Certifier (Check only one)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			St	ate of Ma	aryland		artment <i>rtificate</i>			nd M	lental Hy	/gier Reg. 1	-	9 2	3983	
r	Physici	an	1. Decedent's Nama (First, Middla, Last)								2. Date of D Month		Day	Yaer	3. Time of Death	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Tima of Death Month **Physician** Horace Hatmaker 2:30 1999 A.m /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not institution, giva street and number, Examiner Himore If Undar 24 Hrs. 5. Social Security Number 1705 DitGC 7. Age (Inlyrs. lest birthdey, N/A Uh energe 8. Data of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours Min. 13€ M 2 F 406 03 2507 87 Director April 24,1912 Tennessee Usual Rasidance of Decedant the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mentel Hygiene. Important: if itsm 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be notified as 1 ☐ Yas 200 No Director Maryland Anne Arundel Severn 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 86 Burns Crossing Road 21144 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian. Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3X Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Welder Maryland Drydock 8th 18. Mother's Neme (First, Middle, Maidan Sumema) 17. Fether's Neme (First, Middle, Last) Be John Wheeler Hatmaker (not available) 19a. Informant's Neme/Raiationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Pauline Siegman / Daughter 86 Burns Crossing Road Severn, Maryland 21144 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stata Buriel 2 Cremetion 3 Removel from Stete 7/30/99 Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Gonce Funeral Home, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway mann weller 234 Part 1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel MUNDHAMIN EDSI'S disaesa or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner ician and burial-transit certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical Dua to (or as e consequence of): 80 use (ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed has 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Deeth 28e. Dete of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28b. Time of After Neturet Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation or Attend after death Director: 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

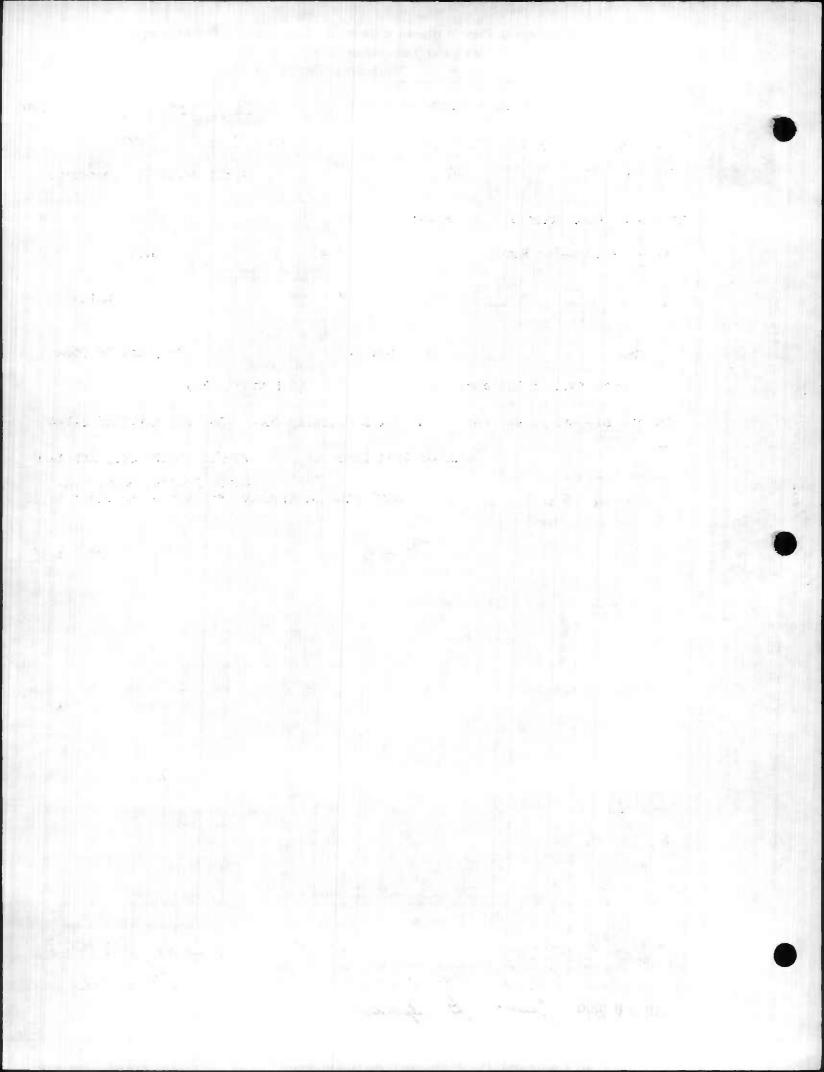
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signetura and title of certifier Ulu use of deathy(term 23e) (Type, Print)

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State Registrar JUL 3 0 1999

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32. Registrer's



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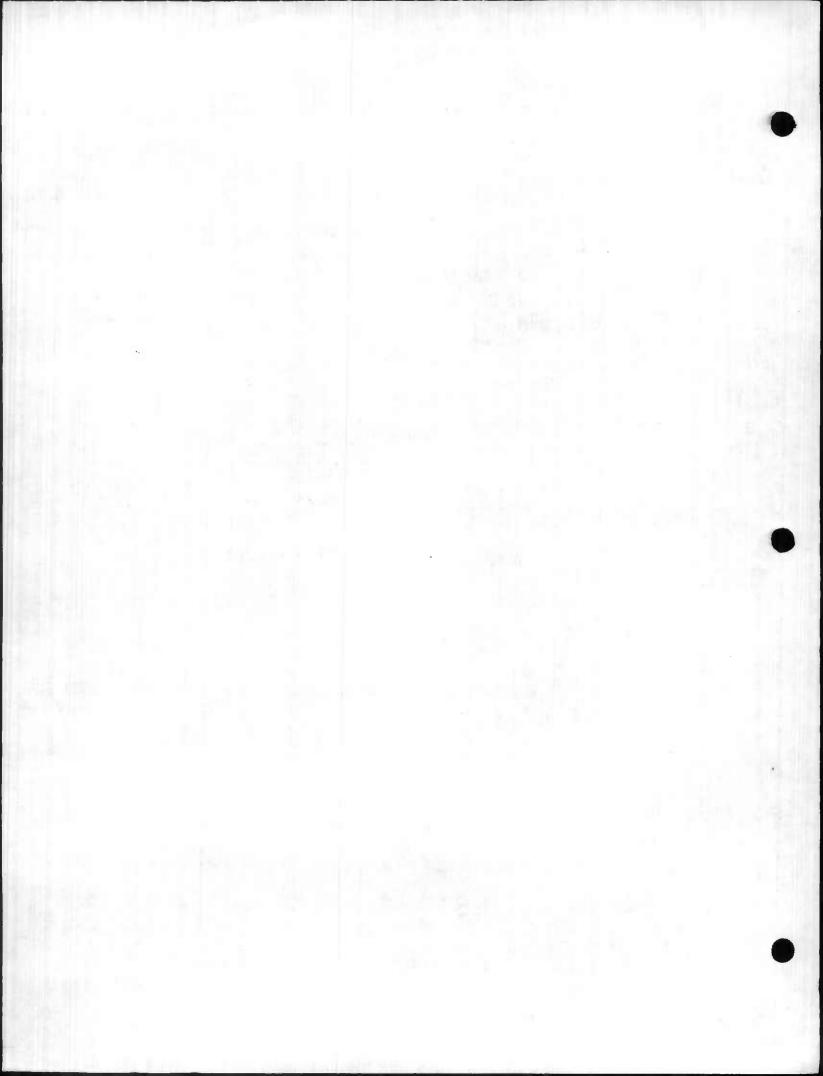
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Joseph Hubbard Sr. July 25 1999 7:30 A.M. /Medical 4s Fscility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Glen Burnie # Under 24 Hrs. 8. Dat Hours Min. (Mo Anne Arundel 5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Ye 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1X M 2□ F 217 30 4471 63 Director Aug. 31, 1935 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Anne Arundel Pasadena 289-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 136 Bar Harbor Road 21122 U.S. 238 Hema ? 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritai Stetus Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Giva
Year or Dates: 1 Never Married 2 Married 21215-0020 6 1 Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer 6th Warehouse Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Hall John Hubbard 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Linda Ohlin 1909 B Halethorpe Avenue Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1⊠ Burial 2 ☐ Cremation 3 ☐ Removel from State Glen Haven Memorial Park 7/28/99 4 □ Donation 5 □ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature-pl Funerel Service Licensee Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 gramerousk nlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) ULMONARY EMBOLISM Examiner Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last the burial-tran pug Due to (or es a consequence of) Box 68760, physician Due to (or es a consequence of): signed by the attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown DIABETES of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificata has 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Daeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ☑ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Neturai 5 Pending investigation ne Hospital or Attendin n 24 hours after death. Ne Funeral Director: Aft pletely filled in by the fu 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifier 017753 morning 1 hos. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.S. DHARMASENA, M.D. 710 CHERCH ST. BALTIMORE, 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

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Registrar

JUL 3 0 1999



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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Tims of Death Month 10:54 pm **Physician** JULY 1999 Ronald Hudgins /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) Villa St. Michael Birthplece (State or Foreign Country) 5. Sociei Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 □ F 218-44-8061 Yrs. Washington D.C **Director** Usual Residence of Decedent parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or have nother traumatic event than "natural", or have nother traumatic event than "natural". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ronald Hodgins 1X Yes 2 □ No Directo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 4800 Saton Drive 21215 U.S.A. Funeral 14. Raca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 Yes 2 No Black Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Public School System Elementery/Secondary (0-12) 12 th grade Coliege (1-4or 5+) Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Samuel Sarah Roberts 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) unknown unknown 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) in State 21. Si na me of Funeral Service Licansee 22. Neme end Address of Facility R nald S. Wade, Director State Anatomy Board, 655 W.

Baltimore, MD 21201

1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ock, or heart tailure. List only one cause on each line. Director State Anatomy Board, 655 W. Baltimore Street Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in deeth) . METASTATIC CANCER OF LUNG IMONTH Examiner Due to (or as a consequence ot) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consaguance ot): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CANCER OF LIVER 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Cirrhosis of the LIVER peen certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Time of 28d Describe how Injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending within 24 hours after death.

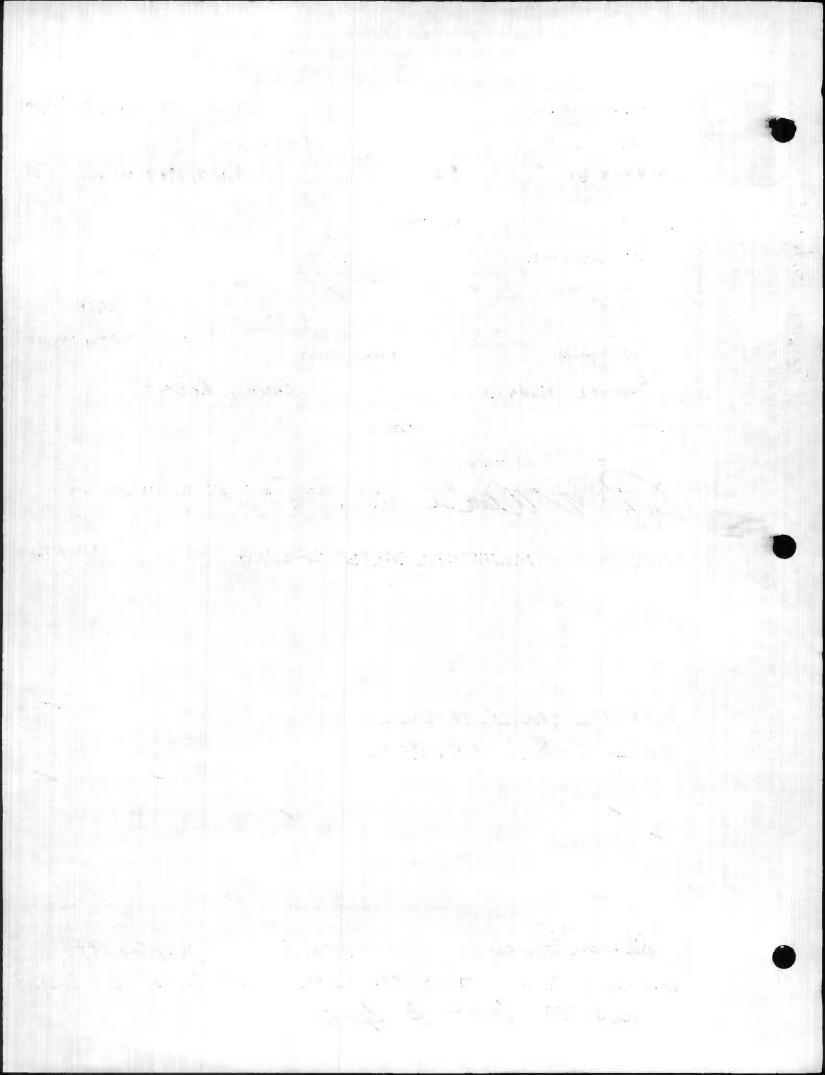
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homlcida 1 Corollying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the I 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Dierce 30. Name and address of person who complated cause of death (Itam 23e) (Type, Print) BALTIMONE IMD 21208 ITEIGHTS AVENUE 7220 PAYLK

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31. Dste tiled (Month, Dey, Year)

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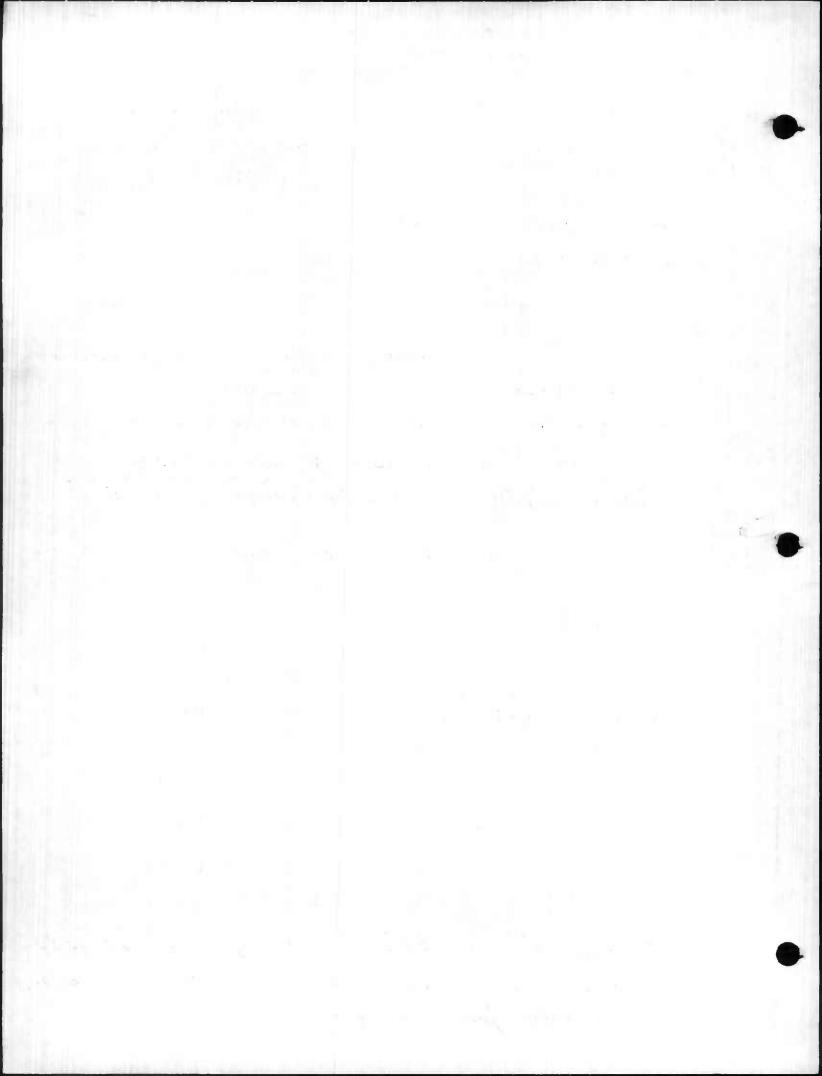
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	or 28	Director	10e. Street and Number			10f. Zip Coda			10g. Citizen of	What Cour	ntry?	
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	25 4		23a. Part1. Entar tha disaasa, or o shock, or haart failura. List o	omplications that caused nly ona causa on aach ii	I tha daath. Do na.	not antar tha moda of dyi	ng, such as cardiac	or raspiratory a	rrast,		Approximata Intarvai Batween Onsat and Death	
	Physician /Medical		Immediata Causa (Final	Moto	atatio	Cancer of the	ho Proctat	-		1	5 years	
1	Examiner		disaasa or condition rasulting in daath)	a			ne Prosta	Le			J years	
		Jer			Dua to (or as a	consequanca of):				1		
) 0°	ificate be executed g physician end as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. —————	Dua to (or as a	consaquance of):						
x 68760,	\$ 00	/Medical	that initialed avants rasulting in death) Last	d	Dua to (or as a	consequanca of):						
. Box	of the off	Physician/N	Part II. Other significant condition		ut not resulting	in the underlying cause of	van in Part i	29h Didd	lobacco una co	ntribute to	the cause of death?	
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Records,	e law requires has been sign ge 2 should be	Completed	Crippling Deg	generative J	oint Di	sease			an autopsy med?	av	ara autopsy findings aliabla prior to mplation of causa daath?	
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Vital	iclan: The	Be	25. Was casa rafarred to medical axaminar?	11			26. Placa of Deat				Accidend	
of	Q 50 X	7	1 Yas 2 No		nt 2 ER/O	utpatient 3L DOA					Assisted Living	
Division of	After fune	Certification:	27. Mannar of Death 12⊡Natural 5 ☐ Panding 2 ☐ Accident invastige	ition	Yaar) 28b.	Tima of 28c. Injury Wo	ry at rk?] Yas 2 No	28d. Dascribe I	now injury occur	red		
Divi	after date of I Directed In by the	Sertific	3 ☐ Suicida 6 ☐ Could no 4 ☐ Homicida datarmir		ury - At homa, fa c. (Spacify)	arm, streat, factory, office		28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)				
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	edicai	29a. Cartifiar 1 ☐ Cartifying (Check only one) 2 ☐ Medicat E	Physician: To the best of xaminar: On the basis of and mannar ste	axamination ar	a, daath occurred at tha ti nd/or invastigation, in my o	ma, data and place, opinion, daath occurr	and dua to the red at tha tima,	causa(s) and ma data and place,	annar as si and dua to	tated. tha causa(s)	
	With To 1	×	29b. Signatura and titla of certifiar **Velleca**	for	2 h	29c. Licans			29d. Data signa			
_	10		30. Nama and addrass of parson w	ho complated causa of d	aath (Itam 23a) 7 20 M	aiden e	hoice l	ane	#10	ato	u. MQ2122	
	Sta Registr		31. Data filad (Month, Day, Year)		ar's Signatura	B. Span	ls)					

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State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death HORNBERGER **Physician** Month GRACE JULY 600 Am /Medical 4e. Fecility Neme (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner BALTIMORE SAMARITAN HOSPITAL BALTIMORE 8. Dete of Birth (Month, Day, Year) Jan. 17, 1909 if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 214-56-3042 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3720 Frankford Avenue 21206 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" or handling or other trainment. 1 ☐ Never Mamed 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: PV 3 X Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondery (0-12) College (1-4or 5+) Cafeteria Worker Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Harry Seabrease Emma Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Leona M. Deal (daughter) 8426 Oakleigh Road Baltimore, Maryland 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/31/99 Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Fecility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, 21214 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirelory errest, shock, or heart tailure. List only one cause on each line. Approximate interval Between Onset and Deeth Physician INFARCTION /Medical Immediate Cause (Final MYUCARDIAL diseese or condition resulting in death) Examiner Due to (or as a consequence ot): CARDIOMYOPATHY 1SCHEMIC burial-transit Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or se a consequence of): and CARCINOMIT Box 68760. Physician/Medical Due to (or as a consequence of) POSSIBLE SEPSI S etten P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown signed by Records, þ 8 TACHYBRADY SYNDROME 24b. Were autopsy findings evelleble prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? RENAL FAILURE (HRUNIC 1 ☐ Yes 2 ₺ No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case reterred to medical Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e, Certifier 29b. Signeture and title of certifier 29c. License number 29d. Dele signed (Month, Day, Year) 0047891 30. Name end address of person who completed cause of death (item 23a) (Type, Print)

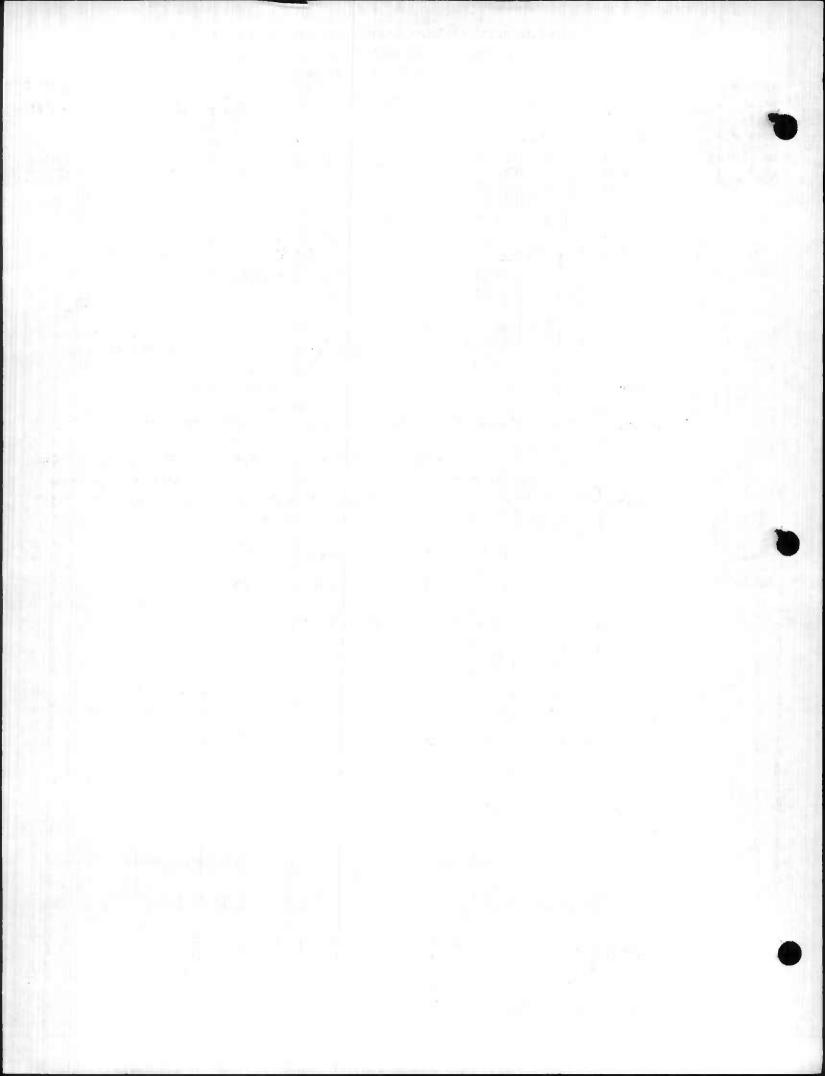
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(ADD D. SAMARITAN #0 SPITAL

State Registrar



BALTIMORE



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month William J. Hardestv 29, 1999 July 2:25 a.m. /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Glen Meadows Retirement Community Glen Arm Baltimore Co. 6. Sex 1 M M 2 ☐ F If Under 1 Yeer If Under 24 Hrs. | Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year, 9. Birthpiace (State or Foreign **Funeral** Months 213-05-2677 90 Yrs. Director Nov. Máryland Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner numb to notified at 1 X Yes 2 ☐ No Maryland Director N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4220 Stanwood Avenue 21206 United States pernit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or thems 23 any injury or other traumatic event, the Hedical Examiner mass. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Production Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norris Hardesty Lillie Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (daughter) 3725 Bayonne Avenue Mrs. Barbara L. Brown Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Gardens 7/31/99 Dorsey, Maryland 21. Signeture of Funerei Service Licensee Michael E. Canapp 22. Name end Address of Fecility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final gressive dementin disease or condition resulting in death) Examiner Due to (or as a consequenca of): strokes The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical attending Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 1 Yas 2No 3 Probably 4 Unknown s been signed to should be dete Records, by 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed page 2 s TO Yes 2 Sevo 1 Yes 2 10 certificate Division of Vital To the Hospital or Attending Physician: "within 24 hours after death.

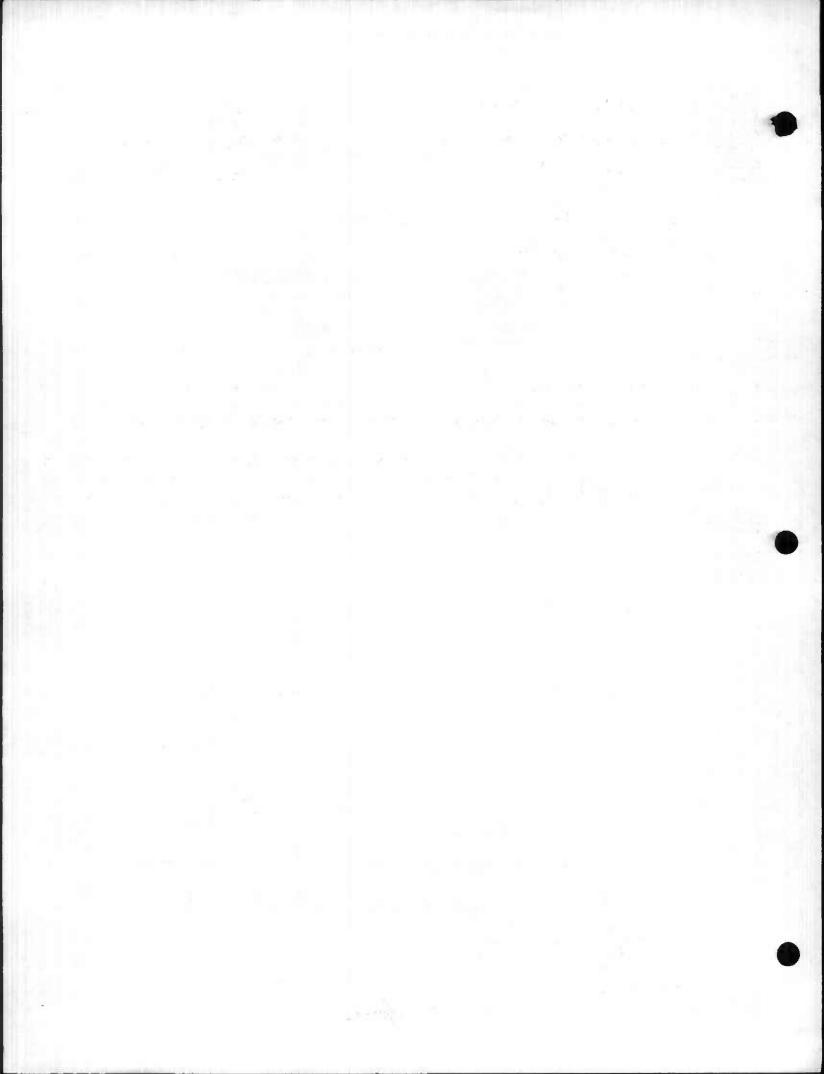
To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: A Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 10 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Medical Certification: 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide to Contrying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cortifier 29b. Signature and tifle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 025205 July 291999 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) W-A. Rilay G-BMC 6701 N. Charles St. BALto. Md 2120x 31. Date filed (Month, Dey, Year) 32. Registrer's Signetule State

DHMH 16 Ray 6/95

Registrar

JUL 3 0 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day pm 10 **Physician** SOY 9 5 /Medical Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner tay box # Under 1 Year 6. Sex 8. Dete of Birth 5. Social Security Number Age (In yrs, last birthday) 9. Birthplaca (State or Foreign **Funeral** Days -18-9380 Months Hours 1 M 2007 **Director** Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow mast be notified at LEYes 2 No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1□ Yes 2□ No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hyglene. Baltimore, Maryland 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental ? int: if Item 27 is marked of R. MONROD 19e. Informent's Name/Reletionship (Type/Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) M/(50) Item 27 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burlel 2 Cremation 3 Removel from Stete = 5 Department of Important: If any Injury or pace. 1222 4 □ Donetion 5 Other (Specify) 21. Signeture of Purpled Service Licenses 23a. Party En er ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in thilure. List only one cause on each line. Approximate Interval Between Onsef and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Box 68760. Due to (or as a consequence of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 MUnknown 1 Yes 2 No Records. à 24b. Wera sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed certificate has page 1 ☐ Yes 2 No 1 Yes of Vital Physician: filled in by the funaral director, 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Dursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To After this 27. Manner of Death 1 Netural 2 Accident 28c. Injury at Work? Hospital or Attending Pl 124 hours after death. Funeral Director: After th 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 No 6 Could not be 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the within 2

State Registrar 31. Date filed (Month, Day, Year)

29b. Signeture and fittle of certifier

32. Registrar's Signeture

30. Name and address of person who completed cause of death (figm 23a) (Type, Print) 3, REFS.H. 560 Koch Kaven Blud, Ballionole fla

29c. License number

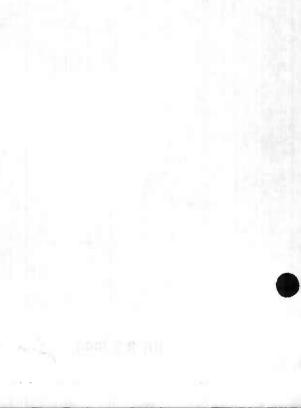
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29d. Date signed (Month, Day, Year)

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Daath 3. Tima of Death **Physician** July 2:300M Wilbert P. Jones /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Villa St. Michael Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Undar 1 Yaar 5. Social Security Number 7. Aga (In vrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 100M 20 F Months Days Yrs. 705-05-3766 Director 87 Dec. 11, 1911 Virginia Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or froms 23s or 28s-f show traumstic event, the Medical Examiner must be notified at the Maryla ty Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4800 Saton Drive U.S.A. 21215 Funeral 14. Race - American Indian. 12. Wes Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Datas: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Master Amtrak Train permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked other any Inlury or other traumatic event, once. 18 Mother's Name (First Middle Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Percy Albert Jones Clara Patterson 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Harriett Jones/spouse 21215 3200 Liberty Heights Ave., Baltimore, MD 20b. Plece of Disposition (Name of comatery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stata Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 X Donation S □ Other (Specify) Roya Ld nature of Funeral Service Licensee 22. Name and Address of Fecility Wade Director State Anatomy Board, 655 W. Baltimore St. well 21201 Baltimore, MD ent1. Enter the usees or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, hock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** THEROSCLEROTIC /Medical Immediate Cause (Finel CDIDUASCULAR disaese or condition rasulting in deeth) Examiner Examiner ician end buriel-trans Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in daath) Last Due to (or as a consequence of): that the death certificate be exec physician Physician/Medical the Dua to (or as a consequanca of): 88 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by t d be datact 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy Completed peen BCUBITUS TO Yes 21 No 1 Yes ZON6 certificate I or Attending Physician: effer death. Director: After this certifica 25. Wes case rafarrad to medical Be 26. Place of Death (Check only one) Other: ursing Homa 5 Rasidance 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral Certification: 27. Menger of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Invastigation 2 Accidant 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homlcide Hospital 24 hours 9 Funeral D

To the Hosp within 24 hor To the Fune completely fi State

edical

29a. Certifier

(Check only one)

Baltimore.

P.O.

Division of Vital

1 ASNEEM 31. Dete tiled (Month, Dey, Year) JUL 3 0 1999

29b. Signature/and title of certifier

Lasneen

MICHANI, 32. Registrar's Signature

7220

alo

30. Name end address of person tho completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

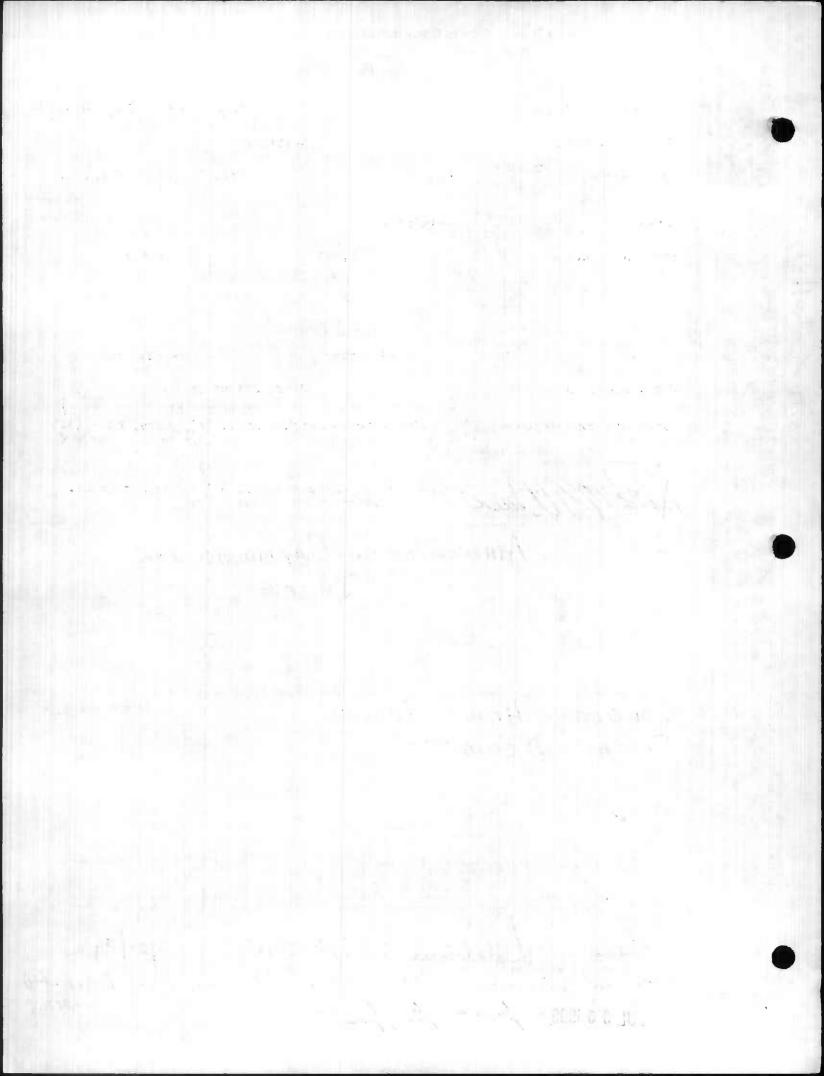
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29d. Date signed (Month, Day, Year)

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DHMH 16 Rev 6/95

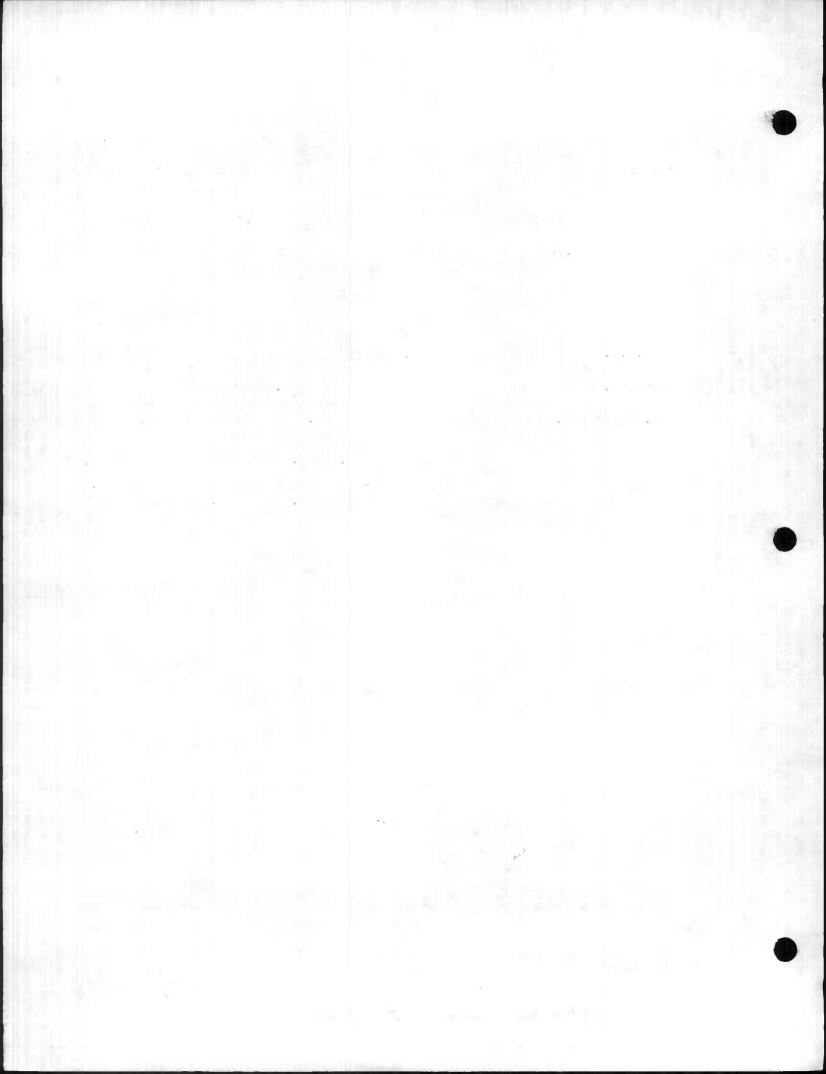
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

				Otate of it	iai yiai ia 7	_	ficate of	Death		Reg. No.	9 2	3992	
	Physici	an	Decedent'a Name (First, Middle, L.	ast) ANDREA	JUNE	JONES	5		2. Date of Dec	Day	Year	3. Time of Death	
3	/Medic		4a Facility Name (If not institution, g			001121		4b. City, Town, or Lo	_	6, 1999		1:20 PM	
	Examir	ier	1021 Elton Aver					Dundall					
	Funeral				ge (In yrs. last		Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da		9. Birthpla	ce (State or Foreign y)	
	Director		220-62-0177 Usual Residence of Decedent	1□M 2,0F	46	Yrs.	lonths Days	Hours Min.	July 2	1,1953		yland	
		tor	tor	10a. State 10b. County Maryland Ba	ltimore	10c. City, To	own or Locati	on	Dund	3276		100	d. Inside City Limits 1 ☐ Yes 2 ☑ No
		Director	10e. Street and Number	I GIMOI C		1	10f. Zip Code	Dunc		10g. Citizen of	What Country	y?	
			1021 Elton Aven	ue 2nd	Floor	4.1		21224	4	Unite	ed Sta	tes	
020	irs efter deal	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes, Give Year or Dates:	?		Decedent of Hes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Ra Bla Specif	ce - Americar ck, White, et y:		
Š	2 hou	8	15. Decedent's E	ducation	10		's Usual Occup			16b. Kind of B			
21215	within 7; ene. then "na	Be Completed	(Specify only highest g. Elementary/Secondary (0-12) G • E • D •	rade completed) College (1-4or	5+)	(Give kind life. DO:	NOT use retired	during most of work d)	ing	Oten	n Home	100	
D	Hygien Hygien	Ö	17. Father's Name (First, Middle, Las	t)		110411041	anc.	18. Mother's Name	e (First, Middle,				
Jan	Ald be the standard s	ToB	James A. Bopp					E. Ja	ane Smit	ch c			
ary	12 should be filed what and Mental Hygie I a marked other thrammetic event, to		19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailing A	ddress (Street	and Number or Run	al Route Number	er, City or Town	, State, Zip C	ode)	
Σ.	and saith		Mr. Stanley D.	Jones/Hus	sband	1021 E	lton Av	ve. 2nd I	Floor I	Dundalk	, MD	21224	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within Department of Ideality and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Money.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		ceme		on (Name of ony or other place Mem. (-0	Date 30/99	20c. Location	- City or Tow e Rive		
Balti	permit. Pa Departmer Important: any Injury ance.		21. Signature of Funeral Service Lice	nsee	Q	22. Na Dud	ame and Addre	ss of Facility Funeral H	Home of	Dundall	k, Inc		
_		-	23 Part 1. Enter the dise vie, or co	C V Ce	d the death O			Ave. Dur					
	01		2 Pm 1. Pinter the dis #0 e, or shock, or heart fail w. List x.	one cause on each	ine.	O HOL OHIER II	ie mode oi dyir	ng, such as cardiac	or respiratory ai	rest,	1 6	Approximate nterval Between Onset and Deeth	
)'	Physician /Medical		Immediate Cause (Final		ara	1-1-	Bra and	Cana				10 1	
	Examiner		disease or condition resulting in death)	a	Due to (or as	duc		il goods					
Ļ.,		Je L			Due to (or as	a consequen	ice oi).				I i		
,	ficete be executed physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or as	a consequen	ice of):						
68760,	physicia physicia the bu	dicai	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as								
×				d							1		
Box	etter 1 for	Ca	Death Other classificant conditions	and the sime to death !		- to the constant		and the Market	non- Plat				
P.O.	ires that the death certif signed by the ettending d be detached for use a	Physician/M	Part II. Other algolificant conditions	contributing to death t	out not resulting	g in the under	nying cause gr	/en in Part I.	236. Did 1	N .		the cause of death?	
Hecords,	ned pon	Completed by								an autopsy med?	com	e autopsy findings lable prior to pletion of cause sath?	
Ž.	he la	Ĕ							101	res 2010			
w w	sician: The law certificate has b lirector, page 2 s		25. Was case referred to medical	T				26 Dines of Deet			10	Yes 2 No	
>	s cert direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 FRA	Outpatient :	3 DOA Ott	26. Place of Deat ner: 4 Nursing Ho			her (Snecify)		
on of	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of Inju	ary 28t	o. Time of Injury	28c. Injur Wor		28d. Describe I				
5	무용하는	Certification:	3 Suicide 8 Could not l	28e. Place of In	jury - At home, ic. (Specify)	farm, street,	factory, office		28f. Location (S City or Tox		ber or Rural I	Route Number,	
	To the Hospital within 24 hours a To the Funeral completely filled	edicai C	29a. Certifier 1 Certifying P. (Check only one) 1 Medical Exa	hysician: To the best miner: On the basis o and manner si	examination :	ge, death oc and/or invest	curred at the tir igation, in my o	me, date and place, ppinion, death occurr	and due to the red at the time,	cause(s) and m date and place,	anner as stat and due to the	ted. he cause(s)	
	Vithin To the	Z e	29b. Signature and title of certifier		^		29c. Licens	e number		29d. Date signe	ed (Month, De	ay, Year)	
	, , , ,		In funcell	Stap Pk	peud		D19	714		7/27/99	7		
			30. Name and address of person who MICHARL PVETE!	completed cause of		a) (Type, Prin		Ave B	ALTIMA	e ml:	4224	1	
	Sta Registra	ie .	31. Date filed (Month, Day, Year)	32. Regišt	ar's Signature	4.	Low	K		1			

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death KEENE **Physician** Month 1/37pm -ULERVERT July /Medical 4b. City, Town, or Location of Dealer 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE SINAL HOSPITAL OF BALTIMORECITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep. 28 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 K 212-22-8483 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltimore MD 1 Yes 2 No Director NA 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Valley USA 1046 21202 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus pernit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "natural", or her any Injury or other traumatic event, are Medical Examine place. 1 □ Never Married 2 □ Merried 1 Yes 2 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Blac Specify: þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secuen ESSEP NA 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Willie Jackson 164 2 DUNNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Runal Route Number, City or Town, State, Zip Code) DROTHER 1046 Valley LEROY Jack 20a. Method of Disposition Dalto NOZ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) wings Mills 16T. RISON TOREST 21. Sonature of Funeral Service Licenses 22. Name and Address of Facility Ave. tavu 21215 4300 Wabash 23a. Part 1. Enter the useese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical ongestive Heart Failure **Examiner** Due to or as a consequence of) Physician/Medical Examiner ebsos ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Box 68760. Due to (or as a consequence of) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown IABETES Records. à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Be Completed DLON CANCER TOYES ZVINO 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Atlanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was ease referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA or of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 V letural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, lerm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 00021730 22 on who completed cause of death (Item 23a) (Type, Print)

HOSPI

SINAL

32. Registrar's Signeture

30. Nama and address of pe

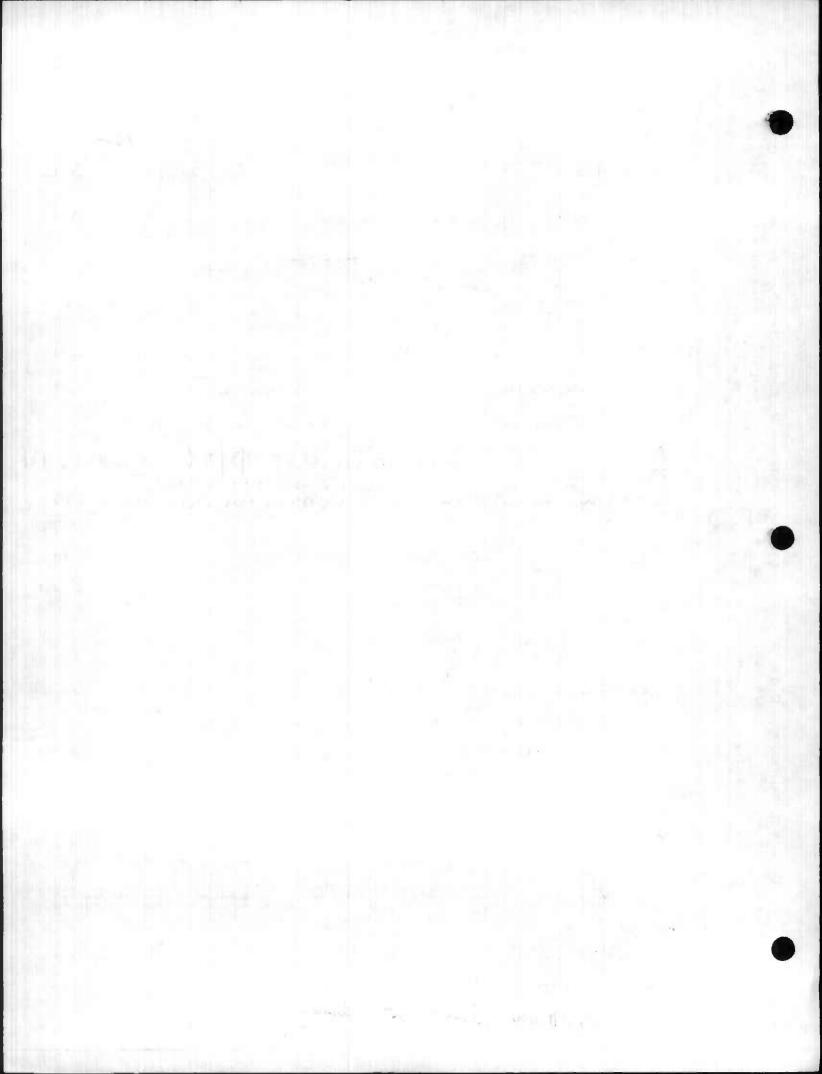
State Registrar

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31. Date liled (Month, Day, Year)

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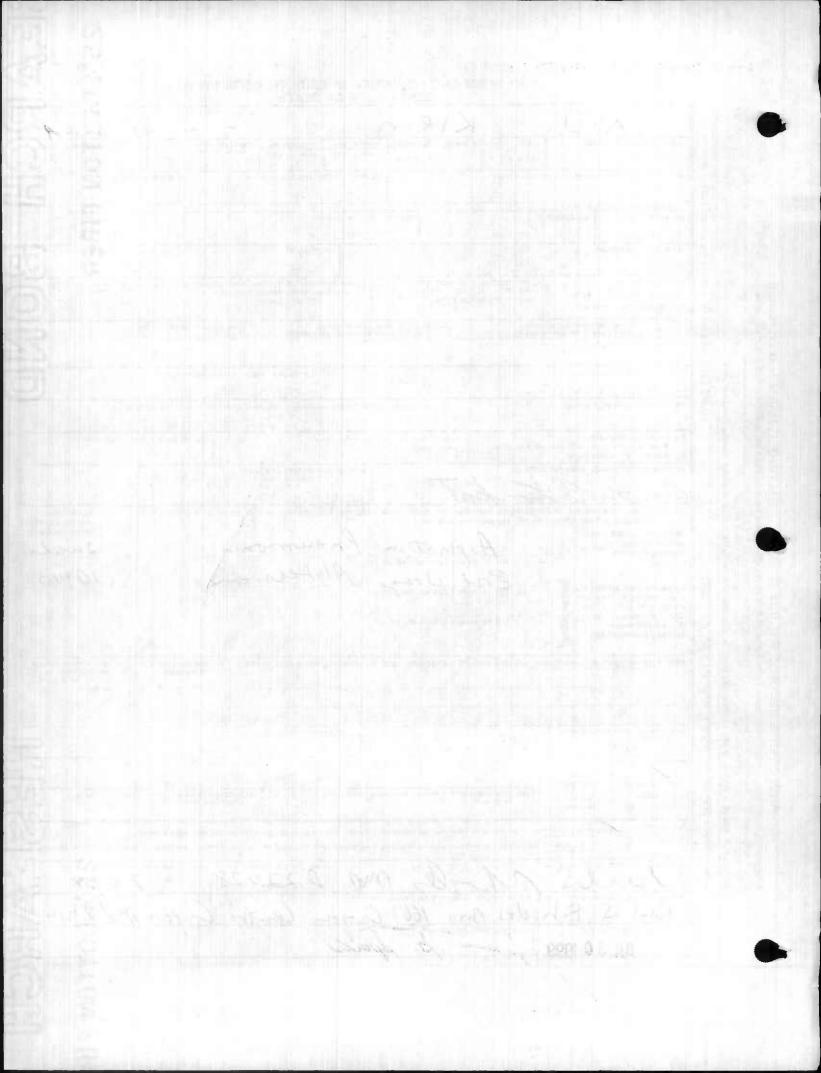
au 31. DATE FILED (Month, Day,

- 1	1. DECEDENT'S NAME (First, Middle, Last)								REG. NO. 2. DATE OF DEATH MONTH DAY				3. TIME OF DE	ATH
- 1	/Vald		KIT	CLV	1				7	4	(79	5:30	1
	4. SOCIAL SECURITY NUMBER 215-50-9155	5. SEX	6. AGE (In yrs. le.	7 6 YRS.	IF UNDER		OURS M	W.	7. DATE OF E (Month, De May 11		23	N. C.		Foreign
DIRECTOR	9a. FACILITY NAME (If not institution, give Crofton Convales of December 1		er			ofto		OF DE	ATH			nne A	Arundel	
	10e. STATE 10b. COUNT			10c. CIT	Y, TOWN O	LOCATION							10d. INSIDE CI	ΓY
		Arundel		A	nnapo								1 TES 2 2	ON
LONERAL	10e. STREET AND NUMBER	A - 4 10	0				CODE						WHAT COUNTRY	
1	803 Coxswain Way,		O EVER IN U.S. AI	DMEO	40.14		21401					S.A.		
	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	YES 2 X		11		y Cuban, M	lexicer	IC ORIGIN7 (S _i n, Puerto Ricer :		or No—		CE — American in ck, Whita, atc. chy: White	
	15. DECEDENT'S EDU (Specify only highest grad		16a. DI	ECEDENT'S	USUAL OC	CUPATION	l warking		16b. KIN	O OF BUS	INESS/IN	VOUSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5	Dit.	Do NOT us	e retired.)					1 -	,			
	17. FATHER'S NAME (First, Middle, Last)	4		Teac	ner					gh S				1
	Clarence T. Poe,	Sr				10			WE (First, Middle illiam		Sumame)			
	19a. INFORMANT'S NAME (Type/Print)	DI.	19	b. MAILING	ADDRESS	(Street and I	4				State 7	Zin Code)		
	19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) Michael Klein/spouse 803 Coxswain Way, #108, Annapolis, MD 21401													
	20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Removal from State 4 (2 Donation 5 Other (Specify)													
1	4 (25 Donation 5 🗆 Other (Specify)													
	Joseph B. Van Sant State Anatomy Board, 655 W. Baltimore St. Baltimore, MD 21201 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate												St.	
1	ahock, or haart fallure.	Complications the List only one car	it caused the de use on each illn	eath. Do r	not enter	tha mode	of dying,	suct	n an cardiac	or reapir	ratory a	rrest,	Approxi	Between
- 11	IMMEDIATE CAUSE (Fine)	/	1.			0.							interval Onset a	IU DOGU
	iMMEDIATE CAUSE (Final disease or condition resulting in death)		Espina			Phe	un	~	mig					el
	disease or condition	DUE TO	COMAS A CONSE			ne	un	~ o	mig					rel
	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. OUE TO	FSPINAS A CONSE			ne Ab.	um Lei	n	nig					elars
	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	OUE TO	OR AS A CONSE	from	Pi:	Phe Ab.	um	n	nig					elars
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	oue to	(OR AS A CONSE	FOUENCE OF	F):					. WAS AN /		Y 24	Onset a 2 Lux	Pekars
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	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X ND	oue to	(OR AS A CONSE	TOWENCE OF	P):	derlying co	BUSE give	n in i	Part I. 24a	. WAS AN / PERFORI	MED?	Y 24	Onset a 2 Luc 10 Y No. WERE AUTOPSY AMILABLE PRIC COMPLETION O OF DEATH?	PACS FINDINGS R TO CAUSE
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions.	c. OUE TO d	OR AS A CONSE OR AS A CONSE death but not ER/Outpatient :	COUENCE OF	OTHER 4 CANurs	26. PLACI	E OF DEAT	H (Che	Part I. 24e	WAS AN I PERFORI	MED?		Onset a 2 Luc 10 Y No. WERE AUTOPSY AMILABLE PRIC COMPLETION O OF DEATH?	PACS FINDINGS R TO CAUSE
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LETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

23995 State of Maryland / Department of Health and Mental Hygiene 🔍 🔾 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:00 A.m 1999 July KAMSCH 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL NORTH ARUNDEL HOSPITAL GLEN BURNIE If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Days 1□M 2 F Months Yrs 77 3, 1922 MARYLAND 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No ANNE ARUNDEL **PASADENA** 10f. Zip Code 10g, Citizen of What Country? 51 WISHING ROCK ROAD 21122 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married If Yes Give 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent'e Education (Specify only highest grade completed) College (1-4or 5+) LINE INSPECTOR WESTINGHOUSE 18 Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) PARKER E. (UNKNOWN) (UNKNOWN) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (SON) 7532 ROCK CREEK WAY, PASADENA, MARYLAND 21122 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Paurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 7/30/99 GLEN BURNIE, MD. 22 Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 21. Signature of Funeral Service Licensee 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 eso e. A COMMITTALIAND STATE THAT COURSE THE DEATH. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximete Interval Between Onset and Deeth DISTASE RENAL END STAGE CARDIOVASCULAR DISEASE HUPERTONINE Due to (or es e consequence of) Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to 24a. Was en eutopsy completion of cause of death? 1 Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Examiner The lew requires that the death certificate be executed Box 68760. 0 Division of Vital Records, Physician: or Attending Figure 1 after death. To the Hosp within 24 ho To the Fune completely fi

Physician

Examiner

Funeral

Director

items 23s or 28s-f show

traumatic event, the Madical Examinar

is marked other than "naturel", or

permit. Pages 1 and 2 Department of Heelth e Important: If Itam 27 ia any Injury or other trai

Physician

/Medical

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After

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filled in by

Examiner

Physician/Medical

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Certification:

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/Medical

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10a State

5. Sociel Security Number

MARYLAND

11. Meritel Status

GEORGE

10e. Street and Number

Elementary/Secondary (0-12)

GEORGE KAMSCH

e dise

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Last

1 Yes 2 No

27. Manner of Death

1- Natural

2 Accident

4 ☐ Homicide

(Check only one)

3 Sulcide

29a. Certifier

216-12-9426

Usual Residence of Decedent

State Registrar

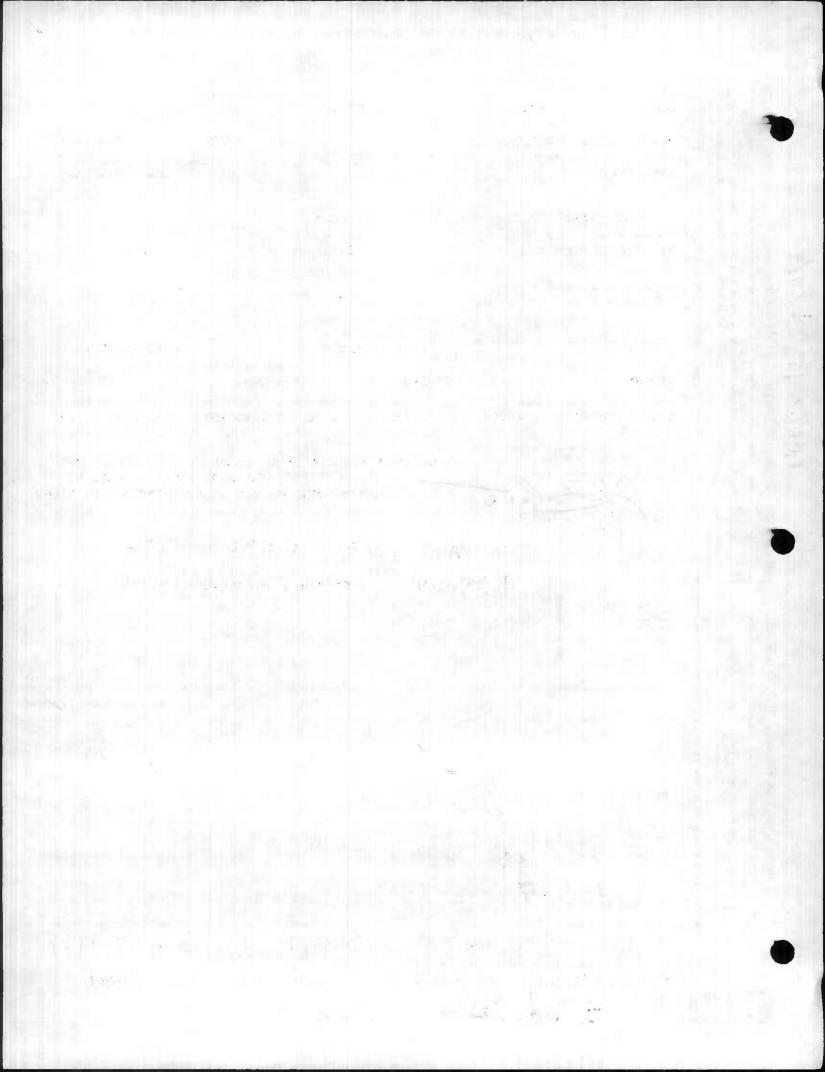
DHMH 16 Rev 6/95

M

Hospital rar's Signature

fress of person who completed ceuse of death (Item 23a) (Type, Print)

301



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Dev **Physician** Anna K. Klima July 28 1999

4b. City, Town, or Location of Death 4c. County of D 10:30 PM /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Kosedale Franklin Square
5. Sociel Security Number 8. Sex Hospital Ce F Under 1 Year Ce H Under 24 Hrs. 8. Dete of Birth Month Day Year April 28, 1920 9. Birthplace (State or Foreign **Funeral** Months Deys 1 M 2 F 79 Mary Land 215-22-5669 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits iral", or items 23s or 28s-f shore Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8301 Allison Lane 21237 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: "natural", or 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: White py 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Press Operator Telephone Company Important: If Itam 27 is marked other any injury or other traumatic event, if 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be and Mental Charles E. Lillian Rice King 0 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Health Mr. George A. Klima (husband) 8301 Allison Lane, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 6 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department 8/2/99 Gardens of Faith Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD a 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final month disease or condition resulting in deeth) Examiner Physician/Medical Examiner inoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or as a consequence of) 68760 Due to (or as a consequence of): Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? P.O. End Stage Renal Disease, Preymoria 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Arteriosclerotic Cardiovascular Disease 1 Yes 2□ No tXYes 2□No Dementia Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To o 27. Menner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attanding After Division 1 Natural 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7746

State Registrar

DHMH 16 Rev 6/95

Anna

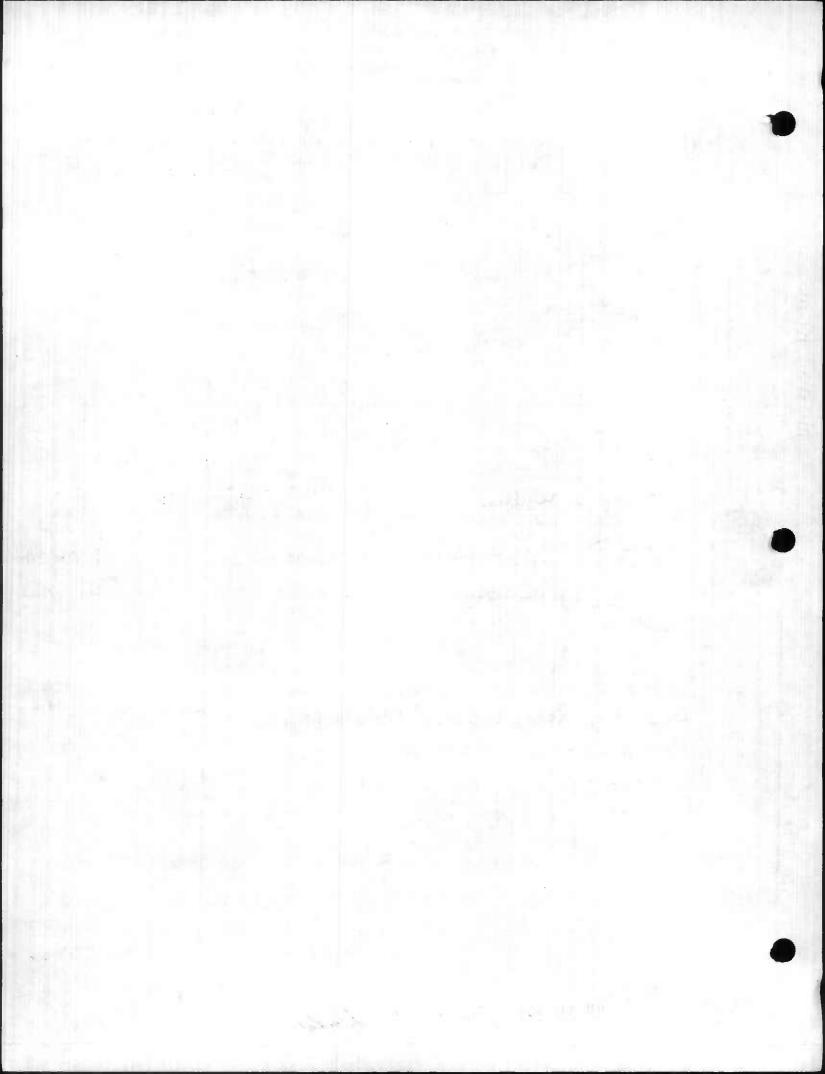
31. Date filed (Month, Day, Year)
JUL 3:0 1999

Dr. Thomas Burke

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

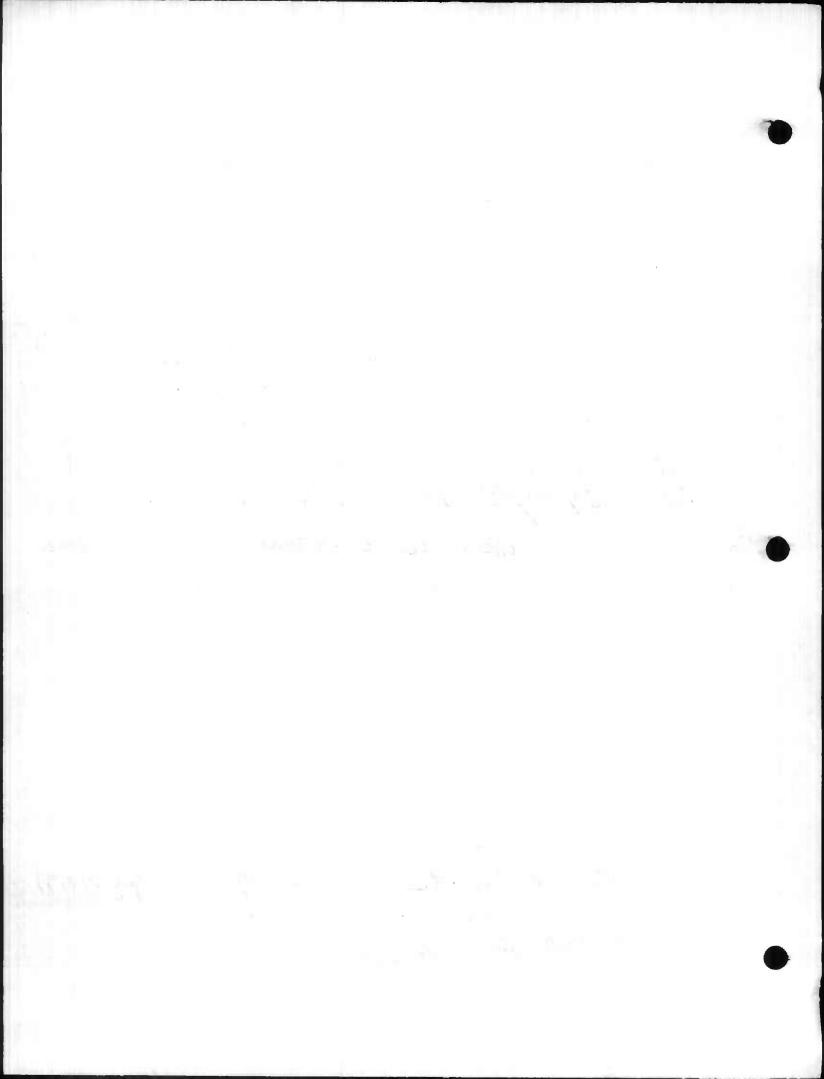
9000 Franklin Square Drive Balt. more, MD 21237



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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within	npletel	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	vent,
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			ENT OF HEALTH AND I	MENTAL HYGIENI REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH					
	Mary Winifred Kenney			July 26.	1999	12:05 p M					
- 1	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.		NOER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		RTHPLACE (State or Foreign untry)					
	265-11-8461 1 M 2 X 89 Se. FACILITY NAME (if not institution, give street and number)	YRS. MONT	CITY, TOWN OR LOCATION OF DE	Sept. 26							
DIRECTOR	Maria Health Care Center		Baltimore		Baltimore						
2	10a, STATE 10b, COUNTY	10c. CITY, TO	WN OR LOCATION		10d. INSIDE CITY						
10	MD Baltimore	Ва	ltimore			1 TES 2 NO					
AL	10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?						
E	6401 North Charles Street		212	12	US	SA					
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 VES 2 IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexica 1 YES 3 NO Specif	in, Puerto Ricen, etc.)	8	Black, White, etc. Specify:					
B	15, DECEDENT'S EDUCATION 16a.	DECEDENT'S USU		16b. KIND OF BUS	INESS/INDUSTR	White					
ET.	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use reti	done during most of working red.)								
COMPLETED	5+	Teach	er	Paroch	ial So	chool					
00	17. FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Malden							
BE	Timothy Edwin Kenney			red A. Do							
2	19a. INFORMANT'S NAME (Type/Print)		N. Charles								
	Bernice Feilinger, SSND		SPOSITION (Name of		CATION — City of						
	4 Burdel B Compation 2 Barrand from Ctata										
	21. SUNATURE OF FUNERAL SEPTICE LICENSEE	Lia Mar	22. NAME AND ADDRESS OF FA	CILITY		MD					
	Amount Albaken Kengy	6	Mitchell W			04040					
\rightarrow	23. PART I. Enter the diseases, or completations that caused the	death. Do not a	6500 York	Rd Balt	ratory arrest	Approximata					
	ahock, or heart fallure. List/only one cause on each	line.	NFANCTION	}		Interval Between Onset and Death					
	DUE TO (OR AS A CON	SEQUENCE OF):									
NO	Sequentially list conditions,										
CERTIFICATION	thany, leading to immediate cause. Enter UNDERLYING										
띮	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CON	SEQUENCE OF):									
H	resulting in death) LAST										
	PART II. Other aignificant conditions contributing to deeth but n	ot regulting in th	a underlying course given in	Pert I. 24s, WAS AN	ALITOPRY	24b. WERE AUTOPSY FINDINGS					
CAL	The state agriculture obtained to do the better	ot roaditing in a	o and any my count given in	PERFOR	MED?	AMILABLE PRIOR TO COMPLETION OF CAUSE					
MEDIC				1 D YES 3	XNO	OF DEATH?					
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF D	EATH VES I	☐ NO-□ LINCEPTAL	N C		1 WES 2 NO					
AN		LACE OF DEATH (C	4444								
SIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetien		HER: Nursing Home 5 - Residence	& C Other (Specify)							
PHYSICIAN:	27. MANNER OF DEATH 28e. DATE OF INJURY	28b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW I	NJURY OCCURE	D					
ВУ Р	Statuse S Pending (Month, Day, Year) 2 Accident Investigation	INJURY	M 1 YES 2 NO								
ED B	3 Suicide 6 Could not be 28e. PLACE OF INJURY — A building, atc. (Specify)	it home, farm, street	t, factory, office	28f. LOCATION (Street of City or Town, State)	and Number or Ru	iral Route Number,					
ETE	4 Homicide determined										
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge medical examiner on the best of examination end					rse(s) end menner ee stated.					
ш	296. SIGNATURE AND TITLE OF CERTIFIER	1	29c. LICENSE NU	MBER	29d. DATE SIG	NED (Month, Day, Year)					
00	Man X Venos	72	DC 13	73	1	427 1998					
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH		,		1204	0					
	Francis Carmody, MD, 7505		Drive, Tows	on, MD 2	1204						
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATUR Server	B. de	Janear								
	• 114	77				DHMH-16 Rev 1/89					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decadant's Nama (First, Middla, Last) 3 Tour of Courth 2. Data of Daath Month **Physician** 07/27/99 11 p.m. illiam J. Kinling /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Catonsville Charlestown Care Center If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar Birthplece (State or Foreign Country)
 Md 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** Deys **0€** M 2□ F 78 Yrs. 214 14 9290 03/29/1921 Director Usual Rasidance of Decedant the Marylend 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 27 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1☐Yes 2☐No Catonsville Md Baltimore Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code with 1 21228 permit. Peges 1 and 2 should be filed within 72 hours efter death verification of Health and Mentel Hygiane. The transfer other than "natural", or items 23 and plijury or other traumatic event, the Medical Examiner manager. USA Funeral 18 North Rolling Road
11. Marital Status
12. Was Decadent Ever In U.S.
Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puerto Rican, atc.) Raca - Amarican Indian, Bleck, Whita, atc. 11. Marital Status 1 TYas 2 No If Yes, Giva Yaar or Datas: WWII 1 Navar Married 25 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 Ø No Specify: Specify:White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Eiamantary/Sacondary (0-12) Collega (1-4or 5+) Educator Education 12 4 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Emil F. Kinling Anna E. Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) Irene Kinling/wife 18 North Rolling Road, Catonsville, Md21228 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 CCremation 3 ☐ Removal from State Balto Wash Crematory 17/29 4 ☐ Donation 5 ☐ Other (Specify) Laural Md 21. Signature of Funaral Sarvice Licansaa 22. Nama and Address of Facility Sterling Ashton Schwab Funeral Home, Inc 23a. Part 1. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or respiratory errast, shock, or haart failure. List only one causa on aach lina. Mas K Marshal 21228 Approximate Interval Batween Onset and Death **Physician** Days necmonia /Medicai Immediata Cause (Fine) disaasa or condition rasulting in daath) Examiner Dua to (or as a consaguanca of) Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disease or mult) that initiated events resulting in death) Last Dua to (or as a consequence ot): cartificate be Physician/Medical Due to (or as a consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 3 Probably 42 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to 24e. Was an autopsy paga 2 should Completed peeu completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No After this certificate furieral director. 25. Was casa reterred to medical 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) Certification: 27. Manner of Deeth 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima ot 103Netural 5 Panding death. 1 Yas 2 No invastigation 2 Accidant 24 hours efter death Funeral Director: 6 Could not be dataminad 28a. Placa ot injury - At homa, farm, streat, tactory, offica building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homleida ð Hospital 29a. Cartifier (Check only one) 🐔 Certifying Physician: To tha best of my knowledge, death occurred et the time, dete end place, and dua to tha causa(s) and mannar as stated. Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifiar 29c. License number

State Registrar

31. Dete filed (Month, Day, Year)

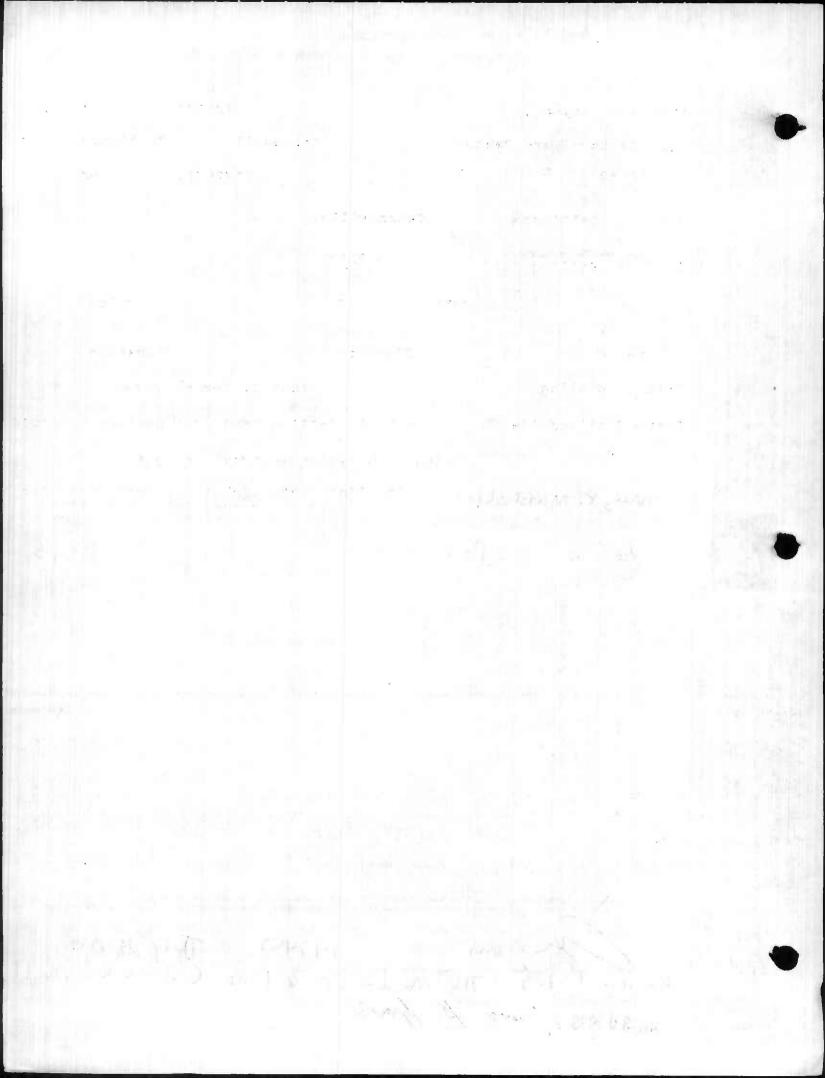
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30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print) Maiden Choice Lane 32. Registrar's Signatura

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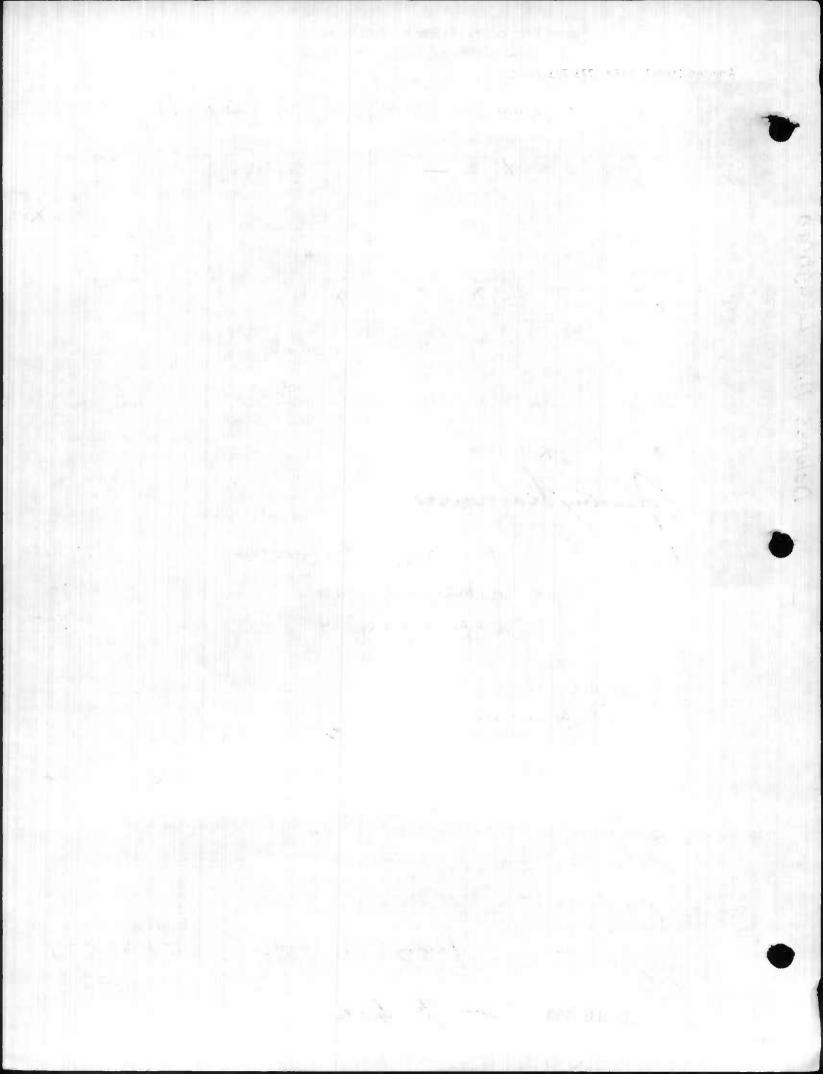
William Kinlin



Dolores Ann Loughran

Physician /Medical	1. Decedent's Name (First, Middle, Last) Dolores Ann Lough	CAN		2. Dete of Deeth Month	Dey 19	Year 199	3. Time of Death 1:25 AM
Examiner	4e Fecility Name (If not institution, give street and number)		4b. City, Town, or Loc		4c. County	of Death	
	Howard County General Hospital	irthdev) If Under 1 Year	Colui			How	
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 80 -79 Usuel Rasidenca of Dacedent	Yrs. Months Deys	Hours Min.	8. Date of Birth (Month, Day, February 9	Year) 9, 1919	9. Birthpie	eca (Stata or Forai ry) Illinois
or 28a-f show be noutled at Director	10a. Stata 10b. County 10c. City, Tow Maryland Howard	wn or Location	Columbia			10	od. Inside City Limi 1 ☐ Yas 2
with the sor 2 and 10 line	10e. Street and Number 10077 #1 Wind Stream Drive	10f. Zip Code	21044	10	g. Citizen of V	hat Count U.S.A	
r hems 23d	11. Mentel Stetus 12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedant of	Hispenic Origin? (Spe ben, Mexican, Puerto F	cify Yes or No-		- America	in Indien,
be filed within 72 hours a tal Hygiene. d other than "natural", o avent, the Madical Exam Be Completed by	1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 200 No If Yes, Give/ Yeer or Dates:	1 ☐ Yas 20 No	Specify:		Specify	k, White, e	vhite
	15. Decedent's Education (Spacify only highast greds completed) Elementary/Secondary (0-12) College (1-4or 5+) "UNK"	a. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin	upetion e during most of workin ed) ememaker	1	6b. Kind of Bu	siness/Indi Hom	
	17. Fether's Neme (First, Middle, Last) Domenico Cavallo		18. Mother's Neme		aiden Sumem nina DiGu		
2 should and Men is marke raumatic		b. Meiling Address (Stree				State, Zip	Code)
Heal Heal Her	Mr. Thomas Loughran Son 20e. Method of Disposition 20b. Place of	7026 Deepag of Disposition (Neme of	e Drive Columb		0c. Location -	City or Toy	en Steta
Se of A	1 Buriel 2 □ Cremation 3 Removal from Stete cemate	ary, crametory or other plants. Blen Eden Memori		7/31/99		ford, Mi	
pemit. Pag Department Important: I any Injury o	21. Signature of Funeral Service Licenses Service Licenses Service Licenses Market Moos 35	22. Name and Addr	1	P.A. ke Ellicott C			
Attanding Physician: The law requires that the death certificate be executed to redeath. Indeath. Sator: After this certificate has been signed by the attending physician end by the funeral director, page 2 should be detached for use as the burial-transit by the funeral director, page 2 should be Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause, Disease or injury that initiated events	consequence of): CLEND SI consequence of): A I NEMIT consequence of):	Anono			1 1 1 1 1 1 1 1 1 1 1	10yrs 10yrs
the atte thed for ysicia	Pert II. Other significant conditions contributing to death but not resulting	In the underlying cause g	given in Part I.	23b. Did tot	acco use cor	ntributa to	the cause of dea
been signed by the after should be detached for letted by Physicia	Hyperreusion			150	s 2□ No	3 Prob	ably 4 Unkn
The law requires the case has been signed, page 2 should be d				24a. Wes an perform	eutopsy ed?	ava	re autopsy finding illable prior to npletion of cause leath?
certificate harector, page				1 7 Yes	~	10	Yes 2No
hysician his certifi if director	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 NEP/O	Outpatient 3 DOA	26. Place of Death	(Check only one ne 5 ☐ Resider		er (Snecily	*)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (7	Time of lnjury 28c. Injury		28d. Describe how			/
or Attendi s after death. Il Director: A od in by the fi	3 Suicide 6 Could not be detarmined 28e. Piece of Injury - At homa, 1 building, etc. (Specify)	erm, straat, factory, office	18f. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,	
To the Hospital or Attanding P within 24 hours after death. To the Fundral Director: After t completely filled in by the funeral Medical Certification:	29e. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge 2 Medical Examinar: On the basis of examination and manner stated.						
	29b. Signature and title of certifier	29c. Licar	nsa number	29	d. Data signe	d (Month, L	Day, Year)
To the comment	Maune W/peer	m D:	38190		07	271	1999

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

				Cei	tificat	e of	Death		R	eg. No.))	446	100
	Decedent's Neme (First, Middle, Last)								2. Date of Dear		Mari	3. Time	a of Deeth
Physician Medical	IIIIDMIIA M EDOMBO							JULY			Year 1999	6:	20An
Examiner	4a Facility Neme (If not institution, g 3405 CHESNUT		mber)				4b. City, Town, or Location of Death Ac. County of BALTIMORE N/A			ty of Death			
Funeral Director	5. Sociel Security Number 6. 218-90-2766 Usual Residence of Decedent	Sex 1□M 2⊠F	7. Age (In yrs. Ia		If Under Months	1 Yeer Deys	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey 2/2	Year) 7/62		olece (Steintry) YLAN	te or Foreign
and fand	10a. Stete 10b. County		10c. City	, Town or Lo	cation				-		1	Od. Inaide	City Limits
or 28a-f ah	MD N/	'A		BAL	TIMO								es 2□No
3s or 3		VENUE			10f. Zip	Code	2121	1	1	0g. Citizen of	What Cour	ntry?	
5-UUZU 72 hours after death with the Maryland 72 hours after death with the Maryland 72 hours after 23s or 23s-f ahow 75s or 15s or 15s or 23s-f ahow 75s or 15s or		12. Wes Dece Armed Fo 1 Yes If Yes, Giv Yeer or D	2 N O		Wes Deced i Yes, spec				ecify Yes or No- Rican, etc.)		ace - Americ eck, White, ify:		
Z1Z15-0020 d within 72 hours af plens. r than "natural". or the Medical Exem completed by §		Education	0.03.	16a. Deced	ient's Usue	i Occup	pation			18b. Kind of			
T 5 5	(Specify only highest g Elementary/Secondery (0-12)	rade completed) Coilege (1	I-4or 5+)	life.	DO NOT us	rk done se <i>retire</i>	during mos d)	t of work	ing				
		0		BA	NK T	ELI		aria Mana	e (First, Middle, i	NATIO		ANK	
E age m		,							RNOLD	welden Sume	ime)		
C T N L	19a. Informant's Name/Relationship MR. JACK LESTE				-		end Number		BALYIN			Code)	
0 8 0 ± 6	20a. Method of Disposition 1 SaBurial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from	State C6	ace of Dispo	natory or o	ther pla		s. 7	Date / 27/99	20c. Location			
DEBILLING Department Important: I	21. Signature of Funeral Service Lice	**	77.	22	. Neme en	d Addre	ss of Fecili	tv	ERAL H				-D
	23a. Part1. Enter the disease, or conshock, or heart feilure. List only	Sacy of management of the control of	aused the deeth	اندا	2525	FLI	EET S	ST.	BALTIM	ORE.		2122 Approxin	
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)		Taste		B				arein			Onsel er	Between and Deeth
death certificate be executed the attending physician and of for use as the burial-transit siclan/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	c		as e conseq									
P.O. BOX that the death cert ed by the attending detached for use Physician/M	Pert II. Other significant conditions	contributing to de	eath but not resu	Iting In the u	nderlying c	ause giv	en in Pert I	l.	23b. Did to	bacco usa c	ontributa t	o the caus	na of death?
ss that the greed by the be detached by Phys									1□ Y	08 21PNO	3 Pro	bably 4	Unknown
ecord aw requin is been s 2 should pieted								_	24a. Was e perform		av	ere autopo ailable pri impletion o death?	
The Late has cate has cate has Com									1 □ Y	es 2000	1 [☐Yes 2	No
Of VITAL IP Physician: The this certificate ral director, page To Be Co	25. Was case referred to medical axaminer? 1 Yes 2 No	Hospitel:				Oth	or:		h (Check only on				
Physic rithis of rail direction of the rail	1 Yes 2 No 27. Menner of Death	28a. Dete		ER/Outpatien 28b. Time of		A	4LIN	ursing Ho	me 5 Aeside 28d. Describe h	ence 8 🗆 O		(y)	
UNISION of Attending & after death. Director: After d in by the funer ertification:	1_ Neturel 5 Pending investigeti	on (Mont	h, Dey Year)	Injury	M	8c. Injui Wor	rk? Yes 2□		200. Describe III	Sw injury occi	31160		
DIVISION C ball or Attending P rs after death. al Director: Attert led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homlcide determine	d 256. Piece	of Injury - At hor ag, etc. (Specify)	me, ferm, sir)	eet, fectory	, office			28f. Location (St City or Town	reet and Num n, State)	nber or Rura	al Route N	lumber,
Hospi 4 hou Funer fely fill	29e. Cartifier (Check only one) 1 Certifying P 2 Wedicat Exa	hysician: To the eminer: On the be and menr	best ot my know asis of examineti her steted.	rledge, deeth on and/or inv	occurred restigetion,	at the tir in my c	me, dete an opinion, des	id place, ith occurr	and due to the co	ause(s) and r ete and place	nenner as a , and due to	tated. the caus	ee(s)
To the within 2 To the comple	29b. Signature and title of certifier	n Hel	- me	0		_	o number	3	2	9d. Date sign	~ .	Day, Year	r)
	30. Name and address of person who Daug Man &	completed caus	e of death (Item	23a) (Type,	Print)	Rec	ren	BL	2 1	Be K	ma	212	139
State Registrar	31. Date filed (Month, Dey, Year)	1999 D	egiatrar's Signel	ure 4		Inn	121						,
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